MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

08774

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
#733 Dunkirk apt.
How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jesse Coleman Boyd

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of husband or wife: Jane D. Hammond.
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): July 10, 1864
8. AGE: Years 83 | Months 3 | Days 5 | If less than one day ____ hrs. ____ min.
9. Birthplace Lebanon Pa. (Town, county, and state)
10. Usual occupation machinist - Retired.
11. Industry or business

FATHER
12. Name J. Taylor Boyd
13. Birthplace Balto. Co., Md. (near Pa. Border)

MOTHER
14. Maiden name Louisa Key
15. Birthplace Darlington, Md.

16. Informant A. I. Waldsachs. (son-in-law)
Address 7304 Dunbrook Crt. Dundalk

17. burial (Burial, cremation, or removal. Which?) Date thereof October 18, 1947 (month) (day) (year)
Cemetery or crematory MOUNT LEBANON CEMETERY
Location LEBANON, PENNSYLVANIA
18. Funeral director STEWART & MOWEN COMPANY
Address 108 W. North Ave., Balto., Md.
19. Oct 17 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1947 at 2 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to — 19
and that I last saw h alive on 19
Immediate cause of death — DURATION
Coronary occlusion — Sudden
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. McCarmine M.D.
M. D. or Coroner
Address Dundalk Md. Date signed 10/20/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08764

CERTIFICATE OF DEATH

Reg. Diat. No. 4 /

1. PLACE OF DEATH: Baltimore

County .....

City or town ..... Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Liberty Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Virginia D Akers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife Joseph Akers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 20 1882

8. AGE: Years	Months	Days	If less than one day
64	9	12	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name James H Erb

13. Birthplace Pa

MOTHER 14. Maiden name Susan Smith

15. Birthplace Pa

16. Informant Norman E Erb

Address 22 Liberty Parkway

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 4 1947 (month) (day) (year)

Cemetery or crematory Mount Hope Cem Lambertville

Location Lambertville New Jersey

18. Funeral director Ullrich Funeral Home

Address 2008 Orleans St

19. 10/3/47 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947 at 8:20 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 16 1947 to Oct 2 1947 and that I last saw her alive on Oct 2 1947

	DURATION
Immediate cause of death	
Central Hemorrhage	7 days
Due to Hypertension C-V- Disease	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M B Davis M.D.

M. D. or other

Address Dundalk-22 Md Date signed 10/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
OCT 13 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

08765

CERTIFICATE OF DEATH

Reg. Diat. No. 57

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Rebecca Alban

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband ~~or wife~~: Wm. H. Alban

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1863

8. AGE: Years	Months	Days	If less than one day
84	8	11	....hrs. ....min.

9. Birthplace: Norrisville, Harford Co., Md.

(Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business

FATHER — 12. Name: John Woodrow

FATHER — 13. Birthplace: Cecil Co. Md.

MOTHER — 14. Maiden name: Sydia Stanbridge

MOTHER — 15. Birthplace: Harford Co.

16. Informant: Mrs. Wm. H. Alban

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 26, 1947 (month) (day) (year)

Cemetery or crematory: Jessops

Location: Sparks Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 10-24 19 47 (Date rec'd by registrar) Wilmer C. Ensor, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/23 1947 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to 10/23 1947 and that I last saw her alive on 10/22/ 1947

Immediate cause of death	DURATION
Pneumocardetis	6 yrs
Due to: Chronic Nefritis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: ....Injured at work?

23. SIGNATURE: Wilmer C. Ensor M. D. ~~or other~~

Address: Cockeysville Md. Date signed 10/23/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08766

97

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Overlea, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 103 Walnut Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ANNA K. ALBRIGHT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joshua T. Albright

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 1st, 1861

8. AGE:

Years	Months	Days	If less than one day
85	11	4	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Martin Bustetter
13. Birthplace: Germany

MOTHER
14. Maiden name: Louise Weingartner
15. Birthplace: Germany

16. Informant: Mrs. Inez L. Struben
Address: 103 Walnut Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/9/47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore, Md.

18. Funeral director: Lassahn Funeral Home.

Address: 7401 Belair Road

19. Oct 7 (Date rec'd by registrar) 19 47 Mrs. A. L. Reference Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH: Oct. 5th 19 47 at 11:55 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 20 19 47 to Oct 5 19 47 and that I last saw her alive on Oct 3, 19 47

Immediate cause of death	Cardiac failure	DURATION
Due to	Generalized arterio-sclerosis with hypertension	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thomas Brennan, M.D. M. D. or other

Address: 5217 Harford Rd Date signed 10-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5501 Edmondson Ave

(c) ~~Hospital or~~ institution: Hood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 08767

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5501 Edmondson Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country Jamaica, B.W.I. Arkansas

3 (a) FULL NAME Lucy E. Arnold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Wm F. Arnold

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 12th 1869

8. AGE: Years	Months	Days	If less than one day
77	11	19	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name (Unknown) Baldwin

FATHER 13. Birthplace "

MOTHER 14. Maiden Name Mary (Unknown)

MOTHER 15. Birthplace "

16 (a) Informant Mrs. Mary Gifford Daughter

(b) Address 1620 Tangerine Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 10/4/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) Oct 2 47 (Date rec'd by registrar) (b) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1st 1947, at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Oct 1 1947, and that I last saw h[er] alive on Aug 1 1947.

Immediate cause of death	Duration
(a) Myocarditis	1 yr
Due to (b) Generalized Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Steve Antonelli M. D.

Address Date signed 10/7

VS 150

VS A15 9-45-15M

Arch E Nichols
Pikesville, Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125b

Registered No. 08768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (Balto)
(b) Street address Pikesville, Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DONNA L BARNES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26-1947

8. AGE: Years 8 Months Days 6 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence L. Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Ethel Richards
15. Birthplace Maryland

16 (a) Informant Clarence L Barnes
(b) Address Pikesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/47 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll Co Md

18 (a) Funeral director Edw A Tipton
(b) Address Hampstead Md

19 (a) OCT 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947, to Oct 2 1947, and that I last saw h.e.d. alive on 19

Immediate cause of death Card.-Resp. Failure -
Due to Cystic Disease of Liver - Type Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation June 4, 1947
Major findings of operation: Hepatomegaly
of autopsy: Cystic Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry C Bowie M. D.
Address 1011 N Calvert St Date signed 10/2/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

08769

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5812 Ethelbert Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: WILLIAM E. BECK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lula Beck

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 4-15-97

8. AGE: Years	Months	Days	If less than one day
50	6	5	....hrs. ....min.

9. Birthplace: Rossville, Md. (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business:

FATHER — 12. Name: Edwin Beck

13. Birthplace: Illinois

MOTHER — 14. Maiden name: Catherine Buehl

15. Birthplace: Catonsville, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 10-31-47 (month) (day) (year)

Cemetery or crematory: ~~Loudon Park~~ Maryland National Cemetery

Location: Baltimore, Md.

18. Funeral director: Leroy Byers

Address: 5005 Park Heights Ave

19. (Date rec'd by registrar) Oct 20, 1947 H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1947 at 5:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16, 1947, to October 20, 1947, and that I last saw him alive on October 20, 1947

	DURATION
Immediate cause of death: Myocarditis, chronic	Unknown
Due to: Coronary Arteriosclerosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Padget

PAUL PADGET, M.D. ACT. CLIN. or DIR.

Address: V.A.H. FORT HOWARD, MD. Date signed: 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08770

BC 156

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Baltimore
City or town Reisterstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred: Mt. Pleasant
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 104 Market Place (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Jennie ~~Berlowitz~~ BERLOWITZ

3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband ~~or wife~~ Samuel Berlowitz
6. (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) May 15, 1879
8. AGE: Years 68 Months 5 Days 9 If less than one day ...hrs. ...min.
9. Birthplace Lithuania (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Sol Meisel
13. Birthplace Lithuania
MOTHER 14. Maiden name Mary Meisel
15. Birthplace Lithuania
16. Informant Samuel Berlowitz
Address 104 Market Place, Balt, Md
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10-26-47 (month) (day) (year)
Cemetery or crematory United Hebrew
Location Washington Boulevard
18. Funeral director JACK LEWIS INC
Address 2100 EUTAW PLACE
19. Oct 25 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1947 at 5 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9, 1947 to Oct. 24, 1947 and that I last saw her alive on Oct. 24 1947

Immediate cause of death	DURATION
Myocardial Failure	
Due to Congestive Heart Failure	2 weeks
Due to Pulmonary Tuberculosis	34 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Cecil Rudner MD M. D. or other
Address Reisterstown, Md Date signed 10/24/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08771

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 74 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1811 Bank Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: FRANK BIALOBRZEWSKI, JR.

3.(b) Social Security Number: 082-14-7981

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4, 1914

8. AGE: Years	Months	Days	If less than one day
33	0	8	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Frank Bialobrzewski
13. Birthplace: Unknown

MOTHER
14. Maiden name: Anna Eoluva
15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15/47 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: Baltimore
18. Funeral director: Fred W. Ozazewski
Address: 1930 Eastern Ave.

19. Oct 14 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1947, at 1:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30, 1947, to Oct. 12, 1947 and that I last saw h im alive on Oct. 12, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis, bilateral	11 Mos
with cavitation right upper lobe	plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Padget
PAUL PADGET, M.D. ACT. CLIN. DIR.
Address: V.A.H. FT. HOWARD, MD. Date signed: 10-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

08772 44

CERTIFICATE OF DEATH

Reg. Dist. No. 2.52

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Q.A.

City or town: Centerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: --

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: EDWARD BONDS

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-18-1890

8. AGE: Years	Months	Days	If less than one day
57	2	5	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: James Bonds

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25-47 (month) (day) (year)

Cemetery or crematory: Bowersville Meth

Location: Queen Anne Co. Md.

18. Funeral director: Leon W. Henry

Address: Easton Md.

19. 10-25-1947 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 1947, at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1947, to October 23, 1947 and that I last saw him alive on October 23, 1947

Immediate cause of death	DURATION
CARCINOMA OF THE STOMACH; METASTATIC TO THE LIVER AND LUNGS	2 mos. plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hubert H. Burns M.D. (A.P.) M. D. or other

Address: V.A.H. Fort Howard, Md. Date signed: 10-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
OCT 27 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08773

95c

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
410 Baltimore Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 410 Baltimore Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: LAURA ANNIE BOWERS

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Alfred A. Bowers
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 20, 1855

8. AGE: Years	Months	Days	If less than one day
92	1	14	— hrs. — min.

9. Birthplace: Hamilton, Ontario, Canada (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Thomas White
13. Birthplace: Cornwall, England

MOTHER
14. Maiden name: Anne Kent
15. Birthplace: Cornwall, England

16. Informant: Anna Mae Bowers
Address: 410 Balto. Ave., Towson, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 5, 1947 (month) (day) (year)
Cemetery or crematory: Merrill Funeral Home
Location: Hudson, Mass.

18. Funeral director: John Burns Sons
Address: Towson, Maryland

19. Oct. 5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28 1947 to October 4 1947
and that I last saw h[illegible] alive on October 2nd 1947

Immediate cause of death	DURATION
Coronary thrombosis	
Due to: coronary arteriosclerosis	about 1½ years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Karl Trautwein M. D. or other
Address: 1623 E. N. Avenue Baltimore Date signed: Oct. 6th 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08775

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: BALTIMORE
City or town: CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred: Haarlem Lodge
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1816 N. Broadway
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: EDWARD JULIUS BRAUER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1914

8. AGE: Years	Months	Days	If less than one day
33	6	5	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: David Edward Brauer
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Margaret F. Gerlach
15. Birthplace: Baltimore, Maryland

16. Informant: Mr. David E. Brauer
Address: 1816 N. Broadway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/27/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. Oct. 25 1947 (Date rec'd by registrar) A. W. Hadrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1947, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1947, to October 23 1947, and that I last saw h... alive on October 23 1947

Immediate cause of death	DURATION
Cardiac failure	3 hrs.
Due to: Aortic insufficiency	?
Due to: Rheumatic fever (?)	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. P. Williamson M. D. (M. D. or other)
Address: 3325 Frederick Ave. Date signed: 10/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08776

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:
County: Baltimore
City or town: Phoenix P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
Blenheim Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Phoenix P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Blenheim Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ORLANDO BRAYSHAW

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Ellen Crumlich
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 14, 1862

8. AGE: Years	Months	Days	If less than one day
85	2	12	— hrs. — min.

9. Birthplace: Sheffield, England (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Supt. Steel Mill
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Mrs. Russell Roof
Address: Phoenix P.O., Balto. Co., Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 27, 1947 (month) (day) (year)
Cemetery or crematory: Heckman Funeral Home
Location: Vandergrift, Penna.
18. Funeral director: John Burns Sons
Address: Towson, Md.
19. Oct. 27, 1947 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1947 at 1:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1947 to October 26 1947 and that I last saw him alive on October 26 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions: Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. H. de Queed, M. D. M. D. or other
Address: Cockeysville, Md. Date signed: 10/27/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

18777

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore Co.

City or town: Cockeysville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 mos - 10 days

Hospital, Institution, or street address where death occurred:
Masonic Homes

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wisconsin County:

City or town: Milwaukee
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hotel Randolf.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harriette Florence Adams Boyer Breitenback

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: Theodore A Breitenback

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27 - 1947

8. AGE: Years: 72 Months: 11 Days: 24 If less than one day: hrs. min.

9. Birthplace: Reading Pa
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: Wm A Boyer

13. Birthplace: South of Reading, Pa.

MOTHER 14. Maiden name: Anna E Adams

15. Birthplace: Reading, Pa.

16. Informant: Laura M. Schroeder per C.P. Tipton

Address: Masonic Homes, Cockeysville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (Shipping) Oct 23 1947 (month) (day) (year)

Cemetery or crematory: Crypt - Wisconsin Memorial Pk

Location: Northwest of Milwaukee, Waukesha Co.

18. Funeral director: Wm Cook

Address: St Paul + Preston sts

19. Oct 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21 1947, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1946, to Oct 21 1947 and that I last saw h~~er~~ alive on October 21 1947

Immediate cause of death	DURATION
Coronary occlusion, posterior	1 day
Due to: Artio Sclerosis	years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walter J Kees M.D.
M. D. or other

Address: Cockeysville Md Date signed: 10/24/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938

CERTIFICATE OF DEATH

08778

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Church & Old Court Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Randallstown,

(If outside city or town limits, write RURAL and give nearest town)

Street No. Church & Old Court Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Eugene Thomas Broadus

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lucy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14, 1864

8. AGE: Years: 83 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Caroline Co. Va.
(Town, county, and state)

10. Usual occupation: Minister

11. Industry or business:

FATHER — 12. Name: Thomas Broadus

13. Birthplace: Va.

MOTHER — 14. Maiden name: Maria ?

15. Birthplace: Va.

16. Informant: Dr. Joseph Mason

Address: Randallstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Washington, D.C.

18. Funeral director: Henry S. Washington & Sons

Address: 467 N St. N.W. Washington D.C.

19. Oct 17 47 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: October 14 1947 at 10:42 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-14-'47 to 10-14-'47

aed that I last saw him alive on not seen alive

Immediate cause of death	DURATION
Hemorrhage-Esophageal Varices	5 hrs.
Due to: Hypertensive C. V. Disease	7 rs.
Due to:	
Other conditions: Arteriosclerosis	10 yrs.
Epilepsy	19 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. D. D. Caples Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed: 10-14-'47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

CERTIFICATE OF DEATH

Reg. Dist. No. 08728 1

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Vets.Adm.Hosp., Fort Howard, Maryland

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 422 E. Street, Sparrows Pt., Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: See above.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1

3.(a) FULL NAME: CHARLES J. BROOKES

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/17/88

8. AGE: Years	Months	Days	If less than one day
59	7	7	hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER 12. Name: Charles Brookes

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Phoebe Sharratt

MOTHER 15. Birthplace: England

16. Informant: Clinical Records, Vets.Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/27/47 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore, Maryland

18. Funeral director: Roland Fisher

Address: Dundalk, Md.

19. 10/28/47 (Date rec'd by registrar) H. McLeanmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 1947, at 7:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20, 1947 to October 24 1947 and that I last saw him alive on October 24, 1947

Immediate cause of death	DURATION
Attack of Bronchial asthma, acute.	10 days
Due to: Chronic bronchial asthma	20 yrs.
Due to:	
Other conditions: Chronic right sided cardiac hypertrophy.	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M Cullison
R. M. CULLISON, M. D., CLIN. DIR.
M.D. or other
VAH, FORT HOWARD, MARYLAND

Address: Date signed: 10/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b (8784)

Reg. Diat. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Raspeburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Glenmore Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CASPER J. BRUECKNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret Brueckner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 13th, 1889

8. AGE: Years	Months	Days	If less than one day
58		21	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Grocer

11. Industry or business

FATHER — 12. Name: Joseph Brueckner

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Katherine Gossman

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Mrs. C.J. Brueckner

Address: 18 Glenmore Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/7/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore, Md.

18. Funeral director: Lasalm Funeral Home

Address: 7401 Belair Rd.

19. Oct 7 (Date rec'd by registrar) 19 47 Mo. A. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4th 1947, at 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to October 4th 1947 and that I last saw h.... alive on October 4th 1947

Immediate cause of death	DURATION
Carcinoma of the	
Due to Stomach and Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of stomach and liver Date of op. Aug 13th 1947

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Edward White M. D. or other

Address: 3005 St. Paul St. Date signed: October 4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08781

46e

BU

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years, 1 month, 11 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 19 years, 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2412 Hudson Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Cecelia Buczek

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: James Bucezek

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1896?

8. AGE: Years: 51? Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and State)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: ? August Otremba

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: ? Mary ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-3-47 (month) (day) (year)

Cemetery or ~~crematory~~: ST. STANISLAUS

Location: Baltimore Md.

18. Funeral director: George A Weber

Address: 705 S Ann st

19. Oct 30 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1947, at 6:05 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 18 19 28 to October 29 19 47 and that I last saw h...er alive on October 29 19 47

Immediate cause of death	DURATION
Carcinoma of the colon	indefinite
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Abdominal laparotomy

Date of op. 10-28-47

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 10-29-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

08782

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dewey F. Burnette

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Burnette

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May - 8 - 1903

8. AGE: Years: 44 | Months: 5 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Hospital Attendant.

11. Industry or business

FATHER
12. Name: Willie T. Burnette
13. Birthplace: Virginia

MOTHER
14. Maiden name: Edna Williams
15. Birthplace: Virginia

16. Informant: Ida Burnette
Address: Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-23-47 (month) (day) (year)
Cemetery or crematory: Lorraine Park
Location: Lynchburg - Virginia
18. Funeral director: Edward L. McIntosh
Address: Catonsville - Maryland

19. (Date rec'd by registrar) 10/23 19 47 — A. W. Hedrick, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20, 1947, at 11:55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Strangulation	
Due to: by hanging	
Due to:	
Other conditions: Suicide	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Oct. 20 47
Where did injury occur? Catonsville Baltimore
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public place
Means of injury: Hanging from tree Injured at work? Oct 20. 47

23. SIGNATURE: Geo. M. Kieffer Coroner
M. D. or other
Address: 1010 Fendrom Date signed: Oct 20 47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ENO.

DATE 10/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

08783

CERTIFICATE OF DEATH

Reg. Diat. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town White Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town White Hall Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Elizabeth Burns

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Henry P. Burns
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 9. 1849

8. AGE: Years	Months	Days	If less than one day
98	7	7	hrs. min.

9. Birthplace White Hall, Md (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Garrett Nelson
FATHER 13. Birthplace White Hall. Md
MOTHER 14. Maiden name Sarah E Nelson
MOTHER 15. Birthplace White Hall. Md
16. Informant Mrs Clara Baumgartner
Address White Hall. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 19-1947 (month) (day) (year)
Cemetery or crematory Mineburn
Location White Hall. Md
18. Funeral director Howard S. Marbline
Address White Hall. Md
19. Oct 20 1947 (Date rec'd by registrar) Mrs Howard S. Marbline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1947, at 2 20/p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 to Oct. 16 1947 and that I last saw h.. alive on Oct. 16 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions Hypertension Arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. or other
Address Parkton, Md. Date signed 10/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08784

157e

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, Institution, or street address where death occurred: ---

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war ---

3.(a) FULL NAME: Anne Merryman Carroll

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): September 2, 1906

8. AGE: Years	Months	Days	If less than one day
41	1	26	-- hrs. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Penniman & Brown

FATHER

12. Name: Henry Carroll

13. Birthplace: Phoenix, Md.

MOTHER

14. Maiden name: Anna Merryman

15. Birthplace: Georgia

16. Informant: Mrs. Norton Carroll McDonough

Address: Phoenix, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/30/47 (month) (day) (year)

Cemetery ~~or crematory~~: Immanuel

Location: Glenco, Md.

19. Funeral director: H. W. Meads and Son

Address: 805 N. Calvert Street

19. 10/29 19 47 (Date rec'd by registrar) Wilmer E. Cusx, Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 19 47, at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 19 47, to Oct 28 19 47 and that I last saw h-er alive on Oct 27 19 47

Immediate cause of death	DURATION
Congestive Heart Disease	3-1947
Due to: Congenital Heart Disease	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Bennett A. Stoen M. D. or other

Address: Cockeysville, Md. Date signed 10/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 08785 BC Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 2 months, 2 days
Hospital, institution, or street address where death occurred: Spring Groove State Hospital
How long in hospital or institution? 3 yrs. 2 months, 2days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1522 Gorsuch Avenue (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: John Caskey (John Grant Caskey)
3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Carrie S. Thomas
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 4, 1869

8. AGE: Years	Months	Days	If less than one day
78	7	9	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Construction

FATHER
12. Name: Robert Caskey
13. Birthplace: Lancaster, Pennsylvania

MOTHER
14. Maiden name: Amelia Preece
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital Records
Address: Catonsville, 28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 16-1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto Md

18. Funeral director: Ratt (?) B. M. Walter
Address: Pratt & Stricker Sts

19. 10-15 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13, 1947, at 8:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1944, to October 13, 1947, and that I last saw him alive on October 13, 1947

Immediate cause of death	DURATION
Acute myocardial failure	5 min.
Due to: Hypertensive Cardio-vascular disease	indef.
Generalized arteriosclerosis	indef.
Due to	

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [signature] Isadore Tuerk M. D. or other
Address: Catonsville-28, Md. Date signed 10-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

08786

CERTIFICATE OF DEATH

Reg. Diat. No. 87

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years - 11 mos - 16 days

Hospital, institution, or street address where death occurred:

Masonic Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Mc Daniels

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME Miss Emma Margaretta Caulk

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7-1866

8. AGE: Years	Months	Days	If less than one day
81	6	22	hrs. min.

9. Birthplace Mc Daniel (Town, county, and state) Md

10. Usual occupation Housekeeping

11. Industry or business Short time in Canning factory

FATHER 12. Name Kemp R Caulk

13. Birthplace Mc Daniel Md

MOTHER 14. Maiden name Lena Wittman

15. Birthplace Mc Daniel Md

18. Informant Laura M. Schroeder per C. P. Tipton

Address Masonic Home Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31- 47 (month) (day) (year)

Cemetery or crematory Easton Cemetery

Location Easton Maryland

18. Funeral director Wm Cook

Address St Paul + Preston Sts

19. Oct 30 19 47 (Date rec'd by registrar) Laura M Schroeder per Clemens P Tipton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 19 47, at 6 45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 46, to October 29 19 47

and that I last saw h.er alive on October 29 19 47

Immediate cause of death Cardiac failure — DURATION

Due to Arteriosclerosis — Years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Keen M. D. M. D. or other

Address Cockeysville Md Date signed 10-29-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08787

462

38

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Riderwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Riderwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 72 Jokpa Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William F. Creaghan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary C. Coppinger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/11/1868

8. AGE: Years: 79 Months: 7 Days: 17 If less than one day: hrs. min.

9. Birthplace: Balto Co. Md (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Towson Court

FATHER — 12. Name: Michael F Creaghan

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Kate Reedy

MOTHER — 15. Birthplace: Ireland

18. Informant: Mrs Mary C. Creaghan

Address: N. Jokpa Rd. Riderwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/31/47 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Fremont Ave.

18. Funeral director: D. J. Doherty Sons

Address: 1218 Light St

19. Oct 30 47 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1947 at 6 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Oct 28 1947 and that I last saw him alive on Oct 27 1947

Immediate cause of death: Carcinoma of Colon — DURATION: 6 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Sellman M.D. M. D. or other

Address: Towson Md Date signed: Oct 29 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55 e

08788

CERTIFICATE OF DEATH

Reg. Diat. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Baltimore
City or town McDonogh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
Home
Now long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Owings Mills McDonogh
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Sterling Ellwood Criswell

3. (b) Social Security Number 098-22-6681

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	W	M.

6.(b) Name of husband or wife Annie Rudolph Criswell 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 27 January 1888

8. AGE: Years	Months	Days	If less than one day
59	8	6	..... hrs. ..... min.

9. Birthplace Pikesville Baltimore Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business McDonogh School, McDonogh Md

FATHER
12. Name Brice Criswell
13. Birthplace unknown

MOTHER
14. Maiden name Susan Polke
15. Birthplace Maryland

16. Informant Mrs. Sterling Criswell
Address McDonogh, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1947 (month) (day) (year)
Cemetery or crematory Mt. Olive
Location Randallstown, Md

16. Funeral director Frank H. Merrill
Address Pikesville, Maryland

19 10-4- 19 47 (Date rec'd by registrar) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 October 19 47 at 10 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 19.. to 3 Oct 19 47 and that I last saw him alive on 3 Oct. 19 47

Immediate cause of death	DURATION
Cardiorespiratory failure	2 days.
Due to: carcinoma, site unknown - undetermined	yrs.?
Due to:	
Other conditions: metastases to lungs and brain	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul H. Royer M.D. M. D. or other
Address 211 Church Lane Pikesville Md. Date signed 3 Oct 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08789

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore

City or town Texas (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mo. 12 da

Hospital, Institution, or street address where death occurred: Baltimore County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Amos Edward Daniels

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Not known by Home

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1870

8. AGE: Years	Months	Days	If less than one day
77	2	15	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John H. Daniels

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Jane Adelia Turney

15. Birthplace: Maryland

16. Informant: Mrs Joseph Brickhaus

Address: 4 Colonial Road. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 31 1947 (month) (day) (year)

Cemetery or crematory: Good Shepherd Cem.

Location: Howard County Md.

18. Funeral director: G. Howard Strong

Address: 3207 W. North Ave. Balto. Md.

19. Oct. 30 1947 (Date rec'd by registrar) Wm. J. Schnitzer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30 1947, at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1946 to 10/30 1947 and that I last saw h. alive on 10/29 1947

Immediate cause of death	DURATION
Hypocardiatis —	2 yrs.
Due to: Arterio Clerosis —	
Due to:	
Other conditions: Cerebral Hemorrhage —	1 wk.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Nicholas C. Evans M.D. M. D. or other

Address: Cockeysville Md. Date signed: 10/30/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4879033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mt. Pleasant
Stay in hospital or inst. (yrs., or mos., or days): 3 mos + 21 days.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 810 So. Kenwood Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Chester Dembeck.

3. (b) Social Security Number: 212-03-2319

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

8 (b) Name of ~~husband~~ or wife: Catherine Dembeck
6(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): May 17, 1915

8. AGE:

Years	Months	Days	If less than one day
32	4	15	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Supervisor
11. Industry or business

FATHER
12. Name: Frank Dembeck
13. Birthplace: U.S.A.

MOTHER
14. Maiden name: Madeline Andrews.
15. Birthplace: U.S.A.

16. Informant: Catherine Dembeck.
Address: 810 S. Kenwood Ave.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10-6-47 (month) (day) (year)
Cemetery or ~~crematory~~: St. Stanislaus
Location: Dundalk Ave.
18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe St.
19. 10-4-1947 (Date rec'd by registrar) (C. W. Hedrick) Registrar J.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2, 1947, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 11, 1947, to Oct. 2, 1947, and that I last saw him alive on Oct. 2, 1947.

	DURATION
Immediate cause of death: Myocardial failure	
Due to: Pulmonary Tuberculosis	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: Far advanced Pulmonary Tuberculosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Cecil Prudner MD
M. D. or other
Address: Reisterstown, Md Date signed: 10/2/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30 (1941)

1. PLACE OF DEATH: (a) Baltimore ~~City~~, Maryland
(b) Street address
(c) Hospital or institution: Spring Grove State Hospital Catonsville, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mths. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Rogue Height
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5025 – 55th Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha D. DeMoah

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Stewart DeMoah
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): December 29, 1893

8. AGE: Years: 53 | Months: 9 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Post Office Dept.

FATHER
12. Name: John Donigan
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Cussie Lozen
15. Birthplace: Ohio

16 (a) Informant: Hospital Records
(b) Address: Catonsville, 25, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/41 (month) (day) (year)
(c) Cemetery or crematory: Family Lot
Location: Sunbury, Ohio

18 (a) Funeral director: Edw. A. MacNabb
(b) Address: Catonsville Md.

19 (a) Oct 25 '41 (Date rec'd by registrar) (b) A. W. Hadrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1941, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Earl C. Rogers M.D.
Medical Examiner
Date signed

VS 131

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08792

83a

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

~~Hospital~~, institution, or street address where death occurred:

1235 Maple Ave.

How long in hospital or institution? none.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1235 Maple Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war none.

3.(a) FULL NAME Charles Henry Dinkelman

3.(b) Social Security Number 213-12-8021

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife Rose Norman Dinkleman

6.(c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) September 1, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	7	..... hrs. ..... min.

9. Birthplace Baltimore Maryland

(Town, county, and state)

10. Usual occupation Jeweler

11. Industry or business Jewelry

FATHER 12. Name H. Henry Dinkelman

13. Birthplace Germany

MOTHER 14. Maiden name unknown

15. Birthplace Germany

16. Informant Mrs. Lillian Dinkelman

Address 1235 Maple Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/47 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 10-9 1947 (Date rec'd by registrar) H. D. Holden Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1947 to Oct 9 1947 and that I last saw h... alive on October 7 1947

Immediate cause of death	DURATION
Cerebrovascular accident	months
Due to Arteriosclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William Goodman M.D. M. D. or other

Address 1324 Sulphur Spring Road Baltimore 27, Md. Date signed 8 October 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08793

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Balto.

City or town: Middle Borough

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Middle borough

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 R T 16 Balto 21 Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3. (a) FULL NAME: Thomas R Elton

3. (b) Social Security Number: 215-10-4315

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 25 1880

8. AGE: Years	Months	Days	If less than one day
67			hrs. ... min.

9. Birthplace: Balto (Town, county, and state)

10. Usual occupation: Stage Worker

11. Industry or business: Theatre

FATHER 12. Name: Geo. F Elton

FATHER 13. Birthplace: Balto Md.

MOTHER 14. Maiden name: Marie P. Limpert

MOTHER 15. Birthplace: Balto Md.

16. Informant: Marie Plummer

Address: Balto, 21 Rt 16 Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10-23-47 (month) (day) (year)

Cemetery or crematory: U S National

Location: Federick Cem

18. Funeral director: J Buzdynski

Address: 1407 Eastern Ave Rd.

19. Oct 21, 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 1947, at 8:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15th 1947, to Oct 20 1947

and that I last saw him alive on October 20 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day.
Due to: Arteriosclerotic Cardio. Renal Vascular Disease	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James H White M.D. M. D. or other

Address: 429 Eastern Ave, Balto 21, Md. Date signed 10/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08794

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County 156 Sassafras Rd Balto.

City or town Middle Borough 21 Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town Middleborough

(If outside city or town limits, write RURAL and give nearest town)

Street No. 156 Sassafras Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Fader.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife Fred A

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 17 - 1890

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace Balto (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Charles F O Hara

13. Birthplace Balto

MOTHER 14. Maiden name Rose McCarris

15. Birthplace Baltimore Md.

16. Informant Fred A Fader

Address 156 Sassafras Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/13/47 (month) (day) (year)

Cemetery or crematory Balto

Location North Ave.

18. Funeral director J J Brudzenske

Address 1407 Eastern Ave

19. Oct 16 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

88

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9th 1947, at 12 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary Occlusion	10 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy (Yes or No) Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ? Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W Bowers M.D. M. D. or other

Address Dundalk Md Date signed 10/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08795

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:
Opitz Nursing Home

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6500 Brook Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY IDA FERGUSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John H. Ferguson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2nd, 1859

8. AGE: Years	Months	Days	If less than one day
88	6	13	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Geo. L Rathell

13. Birthplace

MOTHER 14. Maiden name: Krebs

15. Birthplace

16. Informant: Mr. Wm. M. Ferguson

Address: 6500 Brook Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/18/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore, Md.

18. Funeral director: Lanahan Funeral Home

Address: 7401 Belair Rd.

19. Oct 17 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15th 1947 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Oct 15 1947 and that I last saw h[illegible] alive on Oct 14 1947

Immediate cause of death	DURATION
Chr. Myocarditis -	1 mon
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address [illegible] Date signed 10/17

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08796

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Baltimore.
City or town Villa Nova Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Villa Nova Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rockridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME (or Helen G. Fitzpatrick)
Helen Gertrude Fitzpatrick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9 1883

8. AGE: Years	Months	Days	If less than one day
64		16	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Retired Secretary
11. Industry or business Grear Scott Furn.Co.

FATHER
12. Name Edward D.Fitzpatrick
13. Birthplace Wilmimgton Del.

MOTHER
14. Maiden name Emma E.O'Connor
15. Birthplace Baltimore Md.

16. Informant Alan F.Fitzpatrick
Address Rockridge Road Villa Nova

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 1947 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville Md
18. Funeral director Mary Almacost
Address 4204 Ridgewood Ave

19. 10-27 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1947, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to Oct 25 1947
and that I last saw h alive on Oct 18th 1947

	DURATION
Immediate cause of death Coronary Thrombosis	Few hrs.
Due to Hypertension	Less than yr.
Due to Arterio Sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Medical Examiner Referred 10-25-47
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C B Lewis M. D. or other
Address 4936 York Rd Date signed 10-25-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

BC 08793 Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Opitz Nursing Home - Nunnery Lane
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2811 Echodale Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: Wd

3.(a) FULL NAME: Anna Margaret Flamm

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: George L. Flamm
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 18th 1875
8. AGE: Years: 72 Months: 5 Days: 0 If less than one day: hrs. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: John J. Michel
13. Birthplace: Germany
MOTHER 14. Maiden name: Elizabeth Michel
15. Birthplace: Germany
16. Informant: D. Henry Michel
Address: 2811 Echodale Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/21/47 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul st
19. 10-20 1947 A. W. Aldrich Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18th 1947 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct 18. 1947 and that I last saw her alive on Oct 18 - 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Cerebral Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Date signed: 10/18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08798

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 6 months, 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 6 years, 6 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1738 Patapsco Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Marie Fursch

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Ernest Fursch

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 10, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	28	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: ? Kruse

13. Birthplace: ?

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. (Burial, cremation, or removal. Which?) B. Date thereof 10/11/47 (month) (day) (year)

Cemetery or crematory: Westview Park

Location: Edmondson Ave

18. Funeral director: Geo. W. Lovely

Address: 130 E. Fort Ave.

19. 10/9/47 (Date rec'd by registrar) A. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 20, 1941, to October 7, 1947 and that I last saw her alive on October 7, 1947

Immediate cause of death	DURATION
Terminal pneumonia	24 hours
Due to: Cardiovascular disease	indefinite
Due to: Decubitus, of the back	2 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 10-7-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

COPY.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c

08799

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 6 months, 16 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 6 years, 6 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 101 East Monument Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: James Gaffney

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Cecelia Twibill

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 18, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67	-	5		

9. Birthplace: Philadelphia, Pennsylvania
(Town, county, and state)

10. Usual occupation: Hospital attendant

11. Industry or business: Odd jobs

FATHER
12. Name: Thomas Gaffney
13. Birthplace: Dublin, Ireland

MOTHER
14. Maiden name: Annie Wood
15. Birthplace: Londerry, Ireland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-28-47 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Philadelphia Pa

18. Funeral director: William J. Tickner & Sons

Address: 24th & Pa. Ave. (17) Balto, Md.

19. 10/27 (Date rec'd by registrar) 1947 A. W. Hedrick for T. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 19 47 at 4:55 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fractures of right ulna, tibia, and fibula	
Due to Infected laceration of lower back.	
Due to Bronchopneumonia.	
Pulmonary edema	
Other conditions Senile atrophy of brain Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

(Accident) suicide, or homicide 10/23/47 Date of

Where did injury occur? Rockdale (Randallstown) Md.
(City or town) (State)

Injured at home, farm, industry, public place (where?) Road

Means of injury auto into pedestrian Injured at work? No

23. SIGNATURE: C. S. Merrill MD
M. D. or other

Address: SG 564 Date signed 10/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information called for. Make correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

49a

08800

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Perry Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Perry Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Belair Rd. & Halbert Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: EFFIE M. GALLOWAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: George W. Galloway

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 22nd, 1865

8. AGE: Years	Months	Days	If less than one day
81	11	23	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Fox

13. Birthplace: Frederick County, Md.

MOTHER — 14. Maiden name: Elizabeth Hauver

15. Birthplace: Frederick

16. Informant: Mrs. Geo. Quelet

Address: Belair Rd., Perry Hall

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/18/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: Lasocha Funeral Home.

Address: 7401 Belair Rd.

19. 10/17/47 19..... W. McHammett

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH: Oct. 15th, 19 47 at 8:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 - 19 47, to Oct 15 19 47

and that I last saw h...ed alive on Oct 14 19 47

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to: Carcinoma of Colon	1 yr
Due to:	
Other conditions: Secondary anemia	6 mos

(Include pregnancy within 3 months of death)

Major findings of operation: Colostomy and partial removal of cancerous Date of op. Oct 17-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A Lee Hubert M. D. or other

Address: 1116 Northern Parkway Date signed 10/16/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08801

CERTIFICATE OF DEATH

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Upperco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Upperco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Frances Geist

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John E. Geist
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1861

8. AGE: Years	Months	Days	If less than one day
85	11	26	..... hrs. ..... min.

9. Birthplace: Balto. Co. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
12. FATHER — Name: William Akehurst
13. FATHER — Birthplace: England
14. MOTHER — Maiden name: Ann Hook
15. MOTHER — Birthplace: Md.
16. Informant: Charles Geist
Address: Reisterstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1947 (month) (day) (year)
Cemetery or crematory: Geist Meeting House
Location: Balto. Co.
18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.
19. Nov. 1 (Date rec'd by registrar) 19 47 Cyril E. Fowble M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 19 47, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-5-'47 19 ..... to 10-30-'47 19 ..... and that I last saw her alive on 10-30-'47 19 .....

Immediate cause of death	DURATION
Congestive Broncho Pneumonia	2 days
Due to: Cerebral Hemorrhage	38 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Eagles M.D. M. D. or other
Address: Reisterstown Md. Date signed 11-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08802

CERTIFICATE OF DEATH

Reg. Dist. No. 30

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If ontside city or towo limits, write RURAL and give nearest town)
How long le above place of death? 24 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore
City or towe: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 49 N. Prospect Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rose M. Getterman

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: William E. Getterman
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Jan 3. 1900
8. AGE: Years: 47 | Months: 9 | Days: 26 | If less than one day: hrs. min.
9. Birthplace: Baltimore Md (Town, county and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: William E. Cole
FATHER 13. Birthplace: Md
MOTHER 14. Maidee name: Elizabeth Bruns
MOTHER 15. Birthplace: Md
16. Informant: William E. Getterman
Address: 49 N. Prospect Ave. Catons
17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Nov 1 - 1947
Cemetery or crematory: London Park
Location: 3801 Frederick Ave
18. Funeral director: Mr. Mrs. John W. Tenfel & Son
Address: 5311 Edmondson Ave.
19. (Date rec'd by registrar) Oct 30 1947 R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1947, at 6 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944, to October 29 1947
and that I last saw h[illegible] alive on Oct 28 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. H. Carruthers M. D. or other
Address: 4209 Hudson Ave Date signed 10/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08803

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto Co Md
City or town: Essex Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto Co Md
City or town: Essex Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 121 Riverside Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Virginia E Gilliard

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Scott Gilliard
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 13, 1863

8. AGE:

Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Matth Lentz
13. Birthplace: Va
MOTHER 14. Maiden name: Elizabeth Ambergy
15. Birthplace: Va
16. Informant: Mrs Bessie M Sykes
Address: 121 Riverside Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-21-47 (month) (day) (year)
Cemetery or crematory: Family Burial Ground
Location: Antrip Virginia
18. Funeral director: Albert L Neltz Jr
Address: 1606 N Chester St
19. Oct 21 1947 (Date rec'd by registrar) H W Yadrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1947, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Oct 21 1947 and that I last saw her alive on Oct 21 1947.

	DURATION
Immediate cause of death: Coronary thrombosis	Sudden
Due to: Arteriosclerosis	
Due to: Cardio-Vascular disease	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Baumgardner M. D. or other
Address: Balto 6 Date signed 10-21-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

08804

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Carroll; 9303 Harford Road
City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9303 Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George W. Grinath

3. (b) Social Security Number 212-22-1599

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Cecelia A. Grinath
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) December 8, 1884

8. AGE: Years	Months	Days	If less than one day
62	10	18	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Baker
11. Industry or business
FATHER 12. Name John J. Grinath
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Jessie Euler
15. Birthplace Baltimore, Md.
18. Informant Mrs. Cecelia A. Grinath
Address 9303 Harford Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 29 47 (month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Taylor Ave.
18. Funeral director Howard W. Blight Jr.
Address 6009 Harford Road
19. Oct 29 1947 C. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1947 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to Oct. 26 1947
and that I last saw h alive on Oct 25, 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis Krause M. D. or other
Address 1 E. Chase St. Date signed Oct 27 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08805

932

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years, 4 months, 12 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 32 Years, 4 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bay View Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Mary Hanlon

3.(b) Social Security Number: P

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unk. Michael Hanlon

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: seamstress

11. Industry or business: ?

FATHER — 12. Name: Richard Mooney

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Smith

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 10/7/47 (month) (day) (year)

Cemetery or ~~crematory~~: St. Vincents

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St

19. 10/6 1947 (Date rec'd by registrar) A. V. Hedrick Dpty. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1947, at 6:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1915 to October 4 1947 and that I last saw her alive on October 4 1947

	DURATION
Immediate cause of death: Myocardial insufficiency	2 months
Due to: Generalized arteriosclerosis	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville 28, Md. Date signed 10/4/47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50 08806

CERTIFICATE OF DEATH

Reg. Diat. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 Months
Hospital, institution, or street address where death occurred:
Masonic Home, Cockeysville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Reisterstown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Delight, (Old Church Rd.)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Ida Simpson Harting

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife D. Chas Wm. Harting
6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) May 16 - 1867

8. AGE: Years	Months	Days	If less than one day
80	4	18	..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Housemaid
11. Industry or business

MOTHER FATHER
12. Name James Daniel Simpson
13. Birthplace Ireland
14. Maiden name Eliza McElman
15. Birthplace Baltimore Md
16. Informant Laura M. Schroeder
Address Masonic Home, Cockeysville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7th - 47 (month) (day) (year)
Cemetery or crematory Loudenn Park
Location Baltimore Md.
18. Funeral director Wm. Cook
Address St. Paul & Preston St
19. Oct. 5 19 47 L. M. Schroeder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 19 47 at 11 15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 19 46 to Oct. 4 19 47 and that I last saw h.. alive on Oct. 4 19 47

Immediate cause of death	DURATION
Carcinoma of Left	
Due to Breast	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Left Breast Date of op. April - 47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter T. Kuss M. D. or other
Address Cockeysville Md Date signed 10/4/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08807

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
721 Edmondson Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 721 Edmondson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lula Dale Harvey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1881

8. AGE: Years 66 Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Leonard Belchner

13. Birthplace Germany

MOTHER 14. Maiden name Katharine Reifler

15. Birthplace Maryland

16. Informant Louise Harvey

Address 721 Edmondson Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-27-47 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore Co.

18. Funeral director Edw. L. Magnabosco

Address Frederick Road & Rolling Rd. Catonsville

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1947, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1936, to Oct. 24 1947, and that I last saw her alive on Oct. 24, 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	
Due to: Hypertension	11 yrs.
Due to:	
Other conditions: arteriosclerosis	11 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. M. Heming M.D.
M. D. or other

Address Catonsville, 28 Md. Date signed Oct 25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

111c

bd08808

Reg. Dist. No. XX

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Krause Hotel Camden & Eutaw Sts.

(If rural, give LOCATION)

2.(a) If veteran, name war WW II

3. (a) FULL NAME JOSEPH W. HATSCH

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Florence Hatsch

6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 8/30/09

8. AGE: Years	Months	Days	If less than one day
38	1	5	....hrs. ....min.

9. Birthplace Chicago, Illinois (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER — 12. Name William Hatsch

13. Birthplace Will County, Illinois

MOTHER — 14. Maiden name Elizabeth Zeiglemeir

15. Birthplace Chicago, Illinois

16. Informant Clinical Records Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/47 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director Howard Blight Howard N. Blight

Address 4914 Belair Rd., Balto., Md.

19. 10/8 1947 Ann Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947 at 11:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1947 to October 5 1947 and that I last saw him alive on October 5 1947

	DURATION
Immediate cause of death: Severe pulmonary edema bilateral	21 Hrs.
Due to: Unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE George E. Snider

GEORGE E. SNIDER, M.D. ACT. D. CLIN. DIR.

Address V.A.H.FT. HOWARD, MD. Date signed 10-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 40

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Notch Cliff
(b) Street address Towson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. Mary Hugo Hauger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1867

8. AGE: Years	Months	Days	If less than one day
80	—	23	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Aloysius Hauger
13. Birthplace Bavaria

MOTHER
14. Maiden Name Magdalen Bitriol
15. Birthplace Tyrol

16 (a) Informant Sr. Mary Clara
(b) Address Notch cliff Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/47 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm Md.

18 (a) Funeral director Geo. M. Fyndt & Son
(b) Address 814 W. Lexington St.

19 (a) 10/24/47 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1947, at 2.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1947, to Oct. 23 1947, and that I last saw her alive on Oct. 22 1947.

Immediate cause of death Carcinoma (Sigmoid) — Duration about 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Towson Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08810

Reg. Dist. No. 2-38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since August 30, 1947

Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since August 30, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5709 Whitefield Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Lewis Kyle Heck

3. (b) Social Security Number: 705-07-2281

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Fiona Patterson Heck

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 27, 1876

8. AGE:

Years	Months	Days	If less than one day
70	11	21	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: R R Engineer

11. Industry or business:

FATHER
12. Name: Daniel Webster Heck
13. Birthplace: Virginia

MOTHER
14. Maiden name: Minerva Hall
15. Birthplace: Virginia

16. Informant: Personal History - Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/9/47 (month) (day) (year)

Cemetery or crematory: Woodland Park

Location: Baltimore Co. Md.

18. Funeral director: William Loh Jr.

Address: 1214 E. Coul St.

19. 10-7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1947, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1947, to October 6 1947 and that I last saw h.... alive on October 6 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	.....
Due to	Since about June 1947
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W A Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 10-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46a

CERTIFICATE OF DEATH

08814

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County BALTO

City or town ARBUSTUS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4YRS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO

City or town ARBUSTUS

(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 MAPLE AVE

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FRANK E. HERING

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWER

6.(b) Name of ~~husband or~~ wife DECEASED

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) NOV 7 - 1859

8. AGE: Years 87 | Months 11 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER 12. Name NOT KNOWN

13. Birthplace GERMANY

MOTHER 14. Maiden name NOT KNOWN

15. Birthplace GERMANY

16. Informant MRS. M. DAUGHADAY

Address 125 MAPLE AVE.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11-3-47 (month) (day) (year)

Cemetery or crematory LOUDON PK CEMETERY

Location FRED AVE

18. Funeral director GEO. H. LEIMBACH

Address 525 N. LYNDHURST ST.

19. Nov 3 1947 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1947 at 4:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946, to Oct 31 1947 and that I last saw h.. alive on Oct 30 1947

	DURATION
Immediate cause of death Hemorrhagic shock	6 hrs
Due to carcinoma of oesophagus	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Nathan Ravsin M. D. or other

Address 206 S. Gilmor St. Date signed 11-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47c

BC 08812 44

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital Fort Howard, Md.

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3314 Beverly Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1

3.(a) FULL NAME

WILLIAM B. HODGE

3.(b) Social Security Number

065-03-7883

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Catherine V. Hodge

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): August 16, 1895

8. AGE: Years	Months	Days	If less than one day
52	1	28	....hrs. ....min.

9. Birthplace: Florida
(Town, county, and state)

10. Usual occupation: Telegraph operator

11. Industry or business

FATHER
12. Name: Edwin Hodge
13. Birthplace: Florida

MOTHER
14. Maiden name: Mattie Buckley
15. Birthplace: Florida

16. Informant: Clinical Records, Vets.Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/16/47 (month) (day) (year)

Cemetery or crematory: Long Island National Cemetery

Location: Farmingdale, N.Y.

18. Funeral director: Howard Blight Howard N. Blight

Address: 4914 Belair Road Baltimore, Md.

19. Oct 15 1947 (Date rec'd by registrar) C.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 19 47 at 3:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24 19 47 to October 14 19 47 and that I last saw him alive on October 14 19 47

Immediate cause of death	DURATION
BRONCHOGENIC CARCINOMA WITH GENERALIZED METASTASES	6 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles E. Shaw M.D.
CHARLES E. SHAW, M.D.
M. D. or other
Address: VAH, FT. HOWARD, MD. Date signed: 10/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

526

08813

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Balto.

City or town Phoenix

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

Merryman Hill Rd.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Phoenix

(If outside city or town limits, write RURAL and give nearest town)

Street No. Merryman Hill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME WILLIAM HENIC HODGE

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Mary Blanche Hodge

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	21	..... hrs. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business --

FATHER 12. Name James D. Hodge

13. Birthplace Balto., Md.

MOTHER 14. Maiden name Athelinda Schumard

15. Birthplace Balto., Md.

16. Informant Mrs. Edward G. Rost, Jr.

Address Phoenix, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/47 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Oct 2 19 47 C. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947 at 10:15 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 4, 1944 to Oct. 2 1947

and that I last saw h— alive on October 2 1947

	DURATION
Immediate cause of death Uremia	24 hrs.
Due to Carcinoma of Bladder	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D. M. D. or other

Address Fork, Md. Date signed 10/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

OCCUPATION: letter from son filmed gl13 11-5-47 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

08814

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 E. Susquehanna Ave

(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (a) FULL NAME John Joseph Hoeck - Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Marie C.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 16 1891

8. AGE: Years 56 | Months 8 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation [illegible]

11. Industry or business ACCOUNTANT

FATHER 12. Name ✓

FATHER 13. Birthplace ✓

MOTHER 14. Maiden name ✓

MOTHER 15. Birthplace ✓

18. Informant Mrs. Rita N. Reier

Address 8703 Raven drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/21/47 (month) (day) (year)

Cemetery or crematory Moreland Park

Location Balto Co.

18. Funeral director Leonard J. Buck

Address 5305 Harford Road

19. 10-18 (Date rec'd by registrar) 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1947 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19.. to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Heart disease, chronic, vascular with coronary occlusion (sudden) 10/17/47

Due to .....

Due to .....

Other conditions Cold 3 wks

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Rollin A. Hudson M.D. D.M.E. (M. D. or other)

Address Towson Md Date signed 10/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

08815 44
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Middle River
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address, where death occurred 44 Hawthorne ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Hawthorne ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Andrew H. Hoff **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna E. Hoff
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 21 1879

8. AGE: Years 68 | Months 6 | Days | If less than one day hrs. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual occupation Painter
11. Industry or business
MOTHER FATHER 12. Name Andrew H. Hoff
13. Birthplace Md.
MOTHER 14. Maiden name Francis Summers
15. Birthplace Md.
16. Informant Anna E. Hoff
Address 44 Hawthorne ave
17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct. 14/47 (month) (day) (year)
Cemetery or crematory Parkwood
Location Taylor Ave.
18. Funeral director John A. Mahan
Address 6300 E. Balto. St.
19. 10/13 19 47 H. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 19 47 at 12:20 A.M. P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	5 m
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Graves M.D.
M.D. or other
Address Middle River, Md. Date signed 10-13-47

9531

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163 H

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4031 Penn. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gladys Price Hoffman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: N. Bosley Hoffman
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 10, 1900

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47	7	20		

9. Birthplace: Forston, Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
12. Name of FATHER: George M. Price
13. Birthplace of FATHER: Balto. Co. Md.
14. Maiden name of MOTHER: Missouri Alban
15. Birthplace of MOTHER: Balto. Co. Md.
16. Informant: N. Bosley Hoffman
Address: 4031 Penn. Ave. Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-1-1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Towson
18. Funeral director: J. Scott Brooks
Address: 121 Allegheny Ave. Towson, Md.
19. Oct. 31, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1947 at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None, 19..., to ..., 19...
and that I last saw h... alive on ..., 19...

Immediate cause of death: Illuminating gas poisoning - Suicide — DURATION: 10/30/47
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, (Suicide), or homicide: Suicide — Date of 10/30/47
Where did injury occur? Towson (City or town) Baltimore (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Gas poisoning - Suicide — Injured at work?

23. SIGNATURE: Rollin C. Hudson MD. DHE. (M. D. or other)
Address: Towson Md — Date signed 10/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

08816

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years, 10 months, 11 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 15 years, 10 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Baltimore County: Maryland

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3328 Hudson Street

(If rural, give LOCATION)

2.(a) If veteran, name war: N

3. (a) FULL NAME: Florida Hornberger

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years	Months	Days	If less than one day
71	?	?	____ hrs. ____ min.

9. Birthplace: Harford County, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: Lysander Hornberger

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie Kyle

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 10/4/47 (month) (day) (year)

Cemetery or crematory: Upper Falls

Location: Upper Falls Md

18. Funeral director: Tilson & Lee

Address: 1217 E Fort Ave

19. Oct 3 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1947, at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1931 to October 1 1947 and that I last saw her alive on October 1 1947

Immediate cause of death	DURATION
Cellulitis of right leg	8 days
Myocardial insufficiency	10 days
Due to: Pyelitis	7 days
Arteriosclerotic cardiovascular	
Due to: renal disease —	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Catonsville-28, Md. Date signed: 10-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08817

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred: Opitz Home, Edmondson Ave. & Nunnery

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1615 Holbrook Street

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Ella Jenkins

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 12th., 1866

8. AGE: Years	Months	Days	If less than one day
80	9	28	######## hrs. ######## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Enoch Fenwick Jenkins

13. Birthplace: Baltimore, County

MOTHER — 14. Maiden name: Martha Jennings

15. Birthplace: Baltimore, Md.

16. Informant: Miss. Gertrude E. Lewis

Address: 1615 Holbrook Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/13/47 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Taylor Avenue, Balto: Co

18. Funeral director: George J. Ruth, Inc.

Address: 1735 Harford Avenue

19. 10/11 19 47 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10th., 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 19 47, to Oct. 10 19 47

and that I last saw h[illegible] alive on Sept. 25 19 47

Immediate cause of death	DURATION
Arteriosclerotic C.V. disease	
Due to	
Due to Generalized Arteriosclerosis	
Other conditions Senility	

(Include pregnancy ~~within 3 months of~~ death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. H. Kramer M. D. or other

Address: 140 2 E. Lanvale Date signed: 10-10-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

44a

08818

Reg. Dist. No. 38

1. PLACE OF DEATH: (Balto. Co.)
County
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Clara Jurney

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William H. Jurney
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): January-26-1860

8. AGE:

Years	Months	Days	If less than one day
87	8	27	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: House

FATHER
12. Name: Joseph Shane
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susanna ? ?
15. Birthplace: Maryland

16. Informant: Miss Susanna Jurney (daughter)
Address: 4 Maryland Avenue, Towson

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct-25-47
(month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Baltimore, Maryland

18. Funeral director: Stewart & Mowen Company
Address: 108 W. North Avenue, Balto. Md.

19. Oct 24 19 47 H. W. Hardwick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 19 47 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16. 47 to Oct 23 19 47
and that I last saw her alive on Oct 23. 19 47

Immediate cause of death	DURATION
Coronary Occlusion	1 wk.
Due to: Cerebral Thrombosis	1 wk.
Due to: Hypertension —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Harry Kelly M.D.
M. D. or other
Address: Towson 4 Md. Date signed: 10/24/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462 08819

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dunmire Sta Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Dunmire Sta Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Woodland ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Pauline Kany

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: Frank Kany.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
72	—	—	hrs. min.

9. Birthplace: Hungary
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Philip Faust.
13. Birthplace: Hungary.

MOTHER
14. Maiden name: Mary
15. Birthplace:

16. Informant: Mrs. Mary Barta
Address: 11534 Buckeye Rd Cleveland Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15, 1947 (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Eastern ave.

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk ave.

19. 10/4/47 (Date rec'd by registrar) J. M. Learmonth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to October 15th 47

and that I last saw her alive on October 12th 1947

Immediate cause of death	DURATION
Carcinoma of Rectum	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. W. Thomas M.D.
M. D. or other

Address: Dunmire Sta Md Date signed: 10/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

BC 08822

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 2 mos., 24 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T.B. Sanatorium

How long in hospital or institution? 2 yrs., 2 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2115 Cliftwood Ave., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mr. David B. Keefer

3. (b) Social Security Number: 212-01-7125

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Keefer

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): December 23, 1908

8. AGE:	Years	Months	Days	If less than one day
	38	9	27	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER — 12. Name: Samuel Keefer

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Helen Hummel

15. Birthplace: Baltimore, Maryland

16. Informant: David B. Keefer

Address: 2115 Cliftwood Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1947 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Cem.

Location: 5806 Harford Rd., Balto., Md.

18. Funeral director: Dipple Bros.

Address: 7110 Belair Rd., Balto., Md.

19. Oct. 20, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd 10-22-47 - Dr E.E. Nichols, mw.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1947 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1945 to Oct. 20, 1947 and that I last saw him alive on October 20, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. (M. D. or other)

Address: Mount Wilson, Md. Date signed: 10/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

IN RE:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08823

462

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harlem Lodge Sanitarium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war N

3.(a) FULL NAME Joseph Keehner

3.(b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Myrtle
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 24, 1884
8. AGE: Years 63 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Real Estate
11. Industry or business: Self
FATHER 12. Name: John Keehner
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Anna Marohn
15. Birthplace: Baltimore Md
16. Interment: Myrtle Keehner
Address: 12000 E Belvedere Ave
17. Burial, cremation, or removal. Which?: Burial
Date thereof: 10/25/47 (month) (day) (year)
Cemetery or crematory: Lakewood
Location: Catonsville Md
18. Funeral director: Wilson & Lee
Address: 1217 E Pratt St
19. Oct. 23 1947 (Date rec'd by registrar) H. W. Hendrickson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1947 at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1947 to October 22 1947 and that I last saw h. alive on October 21 1947

Immediate cause of death	DURATION
Cardiac failure	one day
Due to: Intestinal obstruction	3 days
Due to: Cancer - large bowel	?
Other conditions: Paranoid Schizophrenia	?

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer large bowel Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. P. Wellman II M. D.
M. D. or other
Address 3325 Frederick Ave Date signed 10/22/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938 08824

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Aldyth Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ruth Emily Kelley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wilbur T.Kelly

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct.15,1887

8. AGE: Years	Months	Days	If less than one day
69	11	22	..... hrs. ..... min.

9. Birthplace Balto.Co. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Judson C.Mettam

13. Birthplace Balto.Co.

MOTHER

14. Maiden name Maria J.Cole

15. Birthplace Md.

16. Informant Elizabeth Kelley

Address Reisterstown,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct.8,1947 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Balto.Co.

18. Funeral director J.F.Eline & Sons

Address Reisterstown,Md.

19. Oct 7 1947 (Date rec'd by registrar) Mary B.Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 6:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-10 1936 to Oct 6 1947 and that I last saw her alive on Oct 5 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 da
Due to: Hypertensive C-V. Disease	11 yrs
Due to:	
Other conditions: Rheumatic Cardio-Vascular Disease	50 yrs? est.

(Include pregnancy within 3 months of death)

Major findings at operation: None. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None. Date of

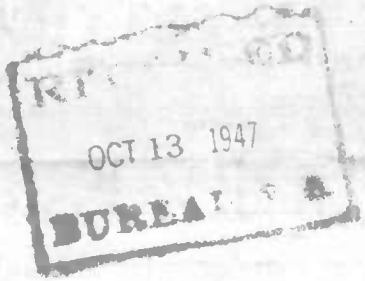
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D.D. Caples, M.D. M. D. or other

Address Reisterstown, Md. Date signed 10-7-47


OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08820

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
OPITZ NURSING HOME
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: BALTIMORE
City or town: ARBUTUS
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4128 WILKENS AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HENRY WILLIAM KESTING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: late ANNA (WECKESER)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOV. 28, 1867

8. AGE: Years	Months	Days	If less than one day
79	10	26	..... hrs. ..... min.

9. Birthplace: BALTO. MD (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business

FATHER
12. Name: ADOLPH KESTING
13. Birthplace: ?

MOTHER
14. Maiden name: CHRISTINE BASS
15. Birthplace: ?

16. Informant: MRS LOUISE PLASSIL
Address: 4128 WILKENS AVE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: OCT. 27/1947 (month) (day) (year)
Cemetery or crematory: WESTERN
Location: EDMONDSON AVE - LONGWOOD ST
18. Funeral director: Harry A Witzke
Address: 410 Edmondson Ave

19. Oct 27 19 47 (Date rec'd by registrar) A. W. Helbach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 19 47 at 2:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1 19 47 to Oct 24 19 47
and that I last saw h... alive on Oct 23 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 Day
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Date signed 10/24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of year of birth shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

08821

FILM No. G 113 NOV -3 1947

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 2 months, 22 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 years, 2 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2879 Woodbrook Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: Joseph A. Kreitz

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: Edna Little

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 28, 1887

8. AGE:

Years	Months	Days	If less than one day
67	2	14	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: plasterer

11. Industry or business: odd jobs

FATHER

12. Name: Andrew J. Kreitz

13. Birthplace: Maryland

MOTHER

14. Maiden name: Annie Wynn

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10/25/47 (month) (day) (year)

Cemetery or ~~crematory~~: Cathedral

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 127 St. Paul st.

19. Oct 25 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 19 47, at 1:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 19 45 to October 22 19 47 and that I last saw him alive on October 22 19 47

Immediate cause of death	DURATION
Spontaneous pneumo-thorax	1 month
Due to pneumonia, left. - Broncho	5 weeks
Due to Generalized arteriosclerosis	Indef.
Bronchogenic Carcinoma ?	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk

Address: Catonsville 28, Md. M. D. or other

Date signed: 10/22/47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08825

93d BC

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5months, 20 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 5 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore-23

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 405 North Payson Street

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME: Teresa Elizabeth Leilich

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Louis Leilich

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): January 16, 1884

8. AGE: Years	Months	Days	If less than one day
63	8	24	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: August Will

13. Birthplace: Germany

MOTHER

14. Maiden name: Margaret Vogts

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (10-13-47) (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: George A. Farley

Address: Fulton ave. & Fayette St

19. Oct 13 1947 (Date rec'd by registrar) A. W. Fredrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1947, at 10:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Acute Cardiac failure

Due to .....

Due to Cardio Vascular disease

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

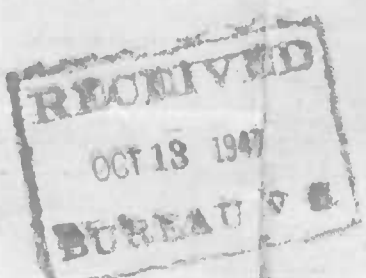
23. SIGNATURE: Geo. McLieffer Dep. Med. Exam'r M. D. or other Balto

Address: 1010 Leeds ave. Date signed: Nov 4 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15


RECEIVED
OCT 13 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836 08826

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
1930 Gwynn Oak Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Woodlawn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1930 Gwynn Oak Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William H. Lippert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah H. Stone
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6th 1866

8. AGE:

Years	Months	Days	If less than one day
81	3	18	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county and state)
10. Usual occupation: Watchman
11. Industry or business: J. Ramsey Barry
FATHER 12. Name: Peter Lippert
13. Birthplace: Germany
MOTHER 14. Maiden name: Annie (Unknown)
15. Birthplace: Germany
16. Informant: Mrs Sarah H. Lippert
Address: 1930 Gwynn Oak Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/27/47 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn Md.
18. Funeral director: John J. Cowan & Son
Address: 901-03 Hollins St.
19. Oct. 25 1947 J.W. Hedrick (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24th 1947 at 3 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1947 to Oct 24 1947 and that I last saw h. / m. alive on Oct 23 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to: Cerebral embolus	
Due to: Arteriosclerosis	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 610 Liberty Hts. Date signed: 10/24/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J. J. C. Baier
815 Eastern Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

08827

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
B-10 Alder Drive, Stansbury Manor

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No.: B-10 Alder Drive, Stansbury Manor
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Eleanor Long

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 26, 1946

8. AGE: Years	Months	Days	If less than one day
1	9	1	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Thomas L. Long
13. Birthplace: Blue Island, Illinois

MOTHER
14. Maiden name: Eleanor Riddle
15. Birthplace: Ravenna, Ohio

16. Informant: Thomas L. Long
Address: B-10 Alder Drive, Stansbury Manor

17. removal (Burial, cremation, or removal. Which?) Date thereof 10/28/47 (month) (day) (year)

Cemetery or crematory: Maple Grove

Location: Ravenna, Ohio

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street

19. Oct 27 - 47 (Date rec'd by registrar) John L. Emmelle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27, 1947, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946, to Oct 27 1947 and that I last saw h...er alive on October 26 1947

Immediate cause of death: Embryoma of Kidney (Wilms tumor) — DURATION: 6 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Wilms Tumor - at University Hospital. Date of op. Sept 6, 1947

Autopsy (yes/no)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John C. Baier M.D.
M. D. or other

Address: 815 Eastern Ave Date signed: 10-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e 08828

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Woodlawn Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5510 Hudson Mill Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Agnes Moffet Lyall

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28 1856

8. AGE:

Years	Months	Days	If less than one day
90	10	27	hrs. min.

9. Birthplace Scotland

(Town, county, and state)

10. Usual occupation

11. Industry or business At home.

FATHER 12. Name Peter Lyall

13. Birthplace Scotland

MOTHER 14. Maiden name Elizabeth Allan

15. Birthplace Scotland

16. Informant William M. S. Ballantyne

Address 5510 Hudson Mill Road

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct 27 1947 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md.

18. Funeral director Harry N. Linwood

Address 4204 Edgewood Ave

19. 10-27 1947 (Date rec'd by registrar) A. C. Leitch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1947 at 6 45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947, to Oct 25 1947

and that I last saw h alive on Oct 24 1947

	DURATION
Immediate cause of death Myocarditis	4 mon.
Due to Old age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. C. Leitch M. D. or other

Address 4509 Filey Ave Date signed Oct 25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

08829

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto.

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Lemnos Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Beulah A. Mack

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C	married

6.(b) Name of husband or wife Edward Mack

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 23rd 1887

8. AGE: Years 60 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Kent Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Edward Watkins

13. Birthplace Kent Co. Md.

MOTHER 14. Maiden name Sadie Maggold

15. Birthplace Kent Co. Md.

16. Informant Edward Mack

Address 325 Lemnos Ave Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10th 1947 (month) (day) (year)

Cemetery or crematory Pleasant Rest

Location Towson, Balto. Co. Md.

18. Funeral director Bysom & Amos & Knight

Address 721 Eutaw St. Balto, Md.

19. 10/10 1947 J. W. Medairy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7, 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to Oct 1 1947 and that I last saw her alive on Oct 1, 1947

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to Coronary Disease	2 yrs.
Due to Acute Dilation of Myocardium	1 wk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clint Green M.D.

M. D. or other

Address Towson Md. Date signed 10/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

08830

CERTIFICATE OF DEATH

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Beckleysville Md Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, Institution, or street address where death occurred: Town Beckleysville Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Mary Land County: Baltimore
City or town: Beckleysville Md Rural (If outside city or town limits, write RURAL and give nearest town)
Street No.: James Beckleysville Rd (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harvey J. Martin

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Virgie Irene Martin
6.(c) If alive, give age: 36 years
7. Birth date of deceased (mo., day, yr.): Sept 20-1876
8. AGE: Years 71 | Months 1 | Days 3 | If less than one day ... hrs. ... min.
9. Birthplace: Mary Land (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Agriculture
FATHER 12. Name: Edward Martin
13. Birthplace: Mary Land
MOTHER 14. Maiden name: Keziah Lawson
15. Birthplace: Mary Land
16. Informant: Virgie Martin
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25/47 (month) (day) (year)
Cemetery or crematory: Salem
Location: Balto Co Md
18. Funeral director: Edw D Tipton
Address: Hampstead Md
19. Oct 24 1947 (Date rec'd by registrar) C E Zentz M.D Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947 at 6 30 A.M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Oct 23 1947 and that I last saw him alive on Oct 22 1947

	DURATION
Immediate cause of death: Chronic Glomerular Nephritis	7
Due to: Arterio-Sclerotic Cardio-Renal Vascular disease	
Due to:	
Other conditions: Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work?

23. SIGNATURE: Joseph E. Buck M.D. M. D. or other
Address: Hampstead Md Date signed: 10-23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08831

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.

County Baltimore

City or town Upperco (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto

City or town Upperco (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary C Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife. Eli Martin

6.(c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Sept 7- 1874

8. AGE: Years	Months	Days	If less than one day
73	1	3	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Samuel Miller

13. Birthplace Md

MOTHER 14. Maiden name Rachel Growther

15. Birthplace Md

16. Informant Eli Martin

Address Hampstead Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct 13/47 (mouth) (day) (year)

Cemetery or crematory Grace

Location Baltimore Md

18. Funeral director Edward Tipton

Address Hampstead Md

19 Oct 12 19 47 (Date rec'd by registrar)

C. E. Fowble M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947 at 11 45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1947 to Oct 10 1947 and that I last saw h alive on October 10 1947

Immediate cause of death	DURATION
Chronic Myocarditis	??
Due to Arterio-sclerotic Cardio v Vascular Disease	
Due to	
Other conditions Chronic Atrophic Arthritis	?

(Include pregnancy within 3 months of death)

Major findings of operation — Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph E Bunk M.D. M. D. or other

Address Hampstead Md. Date signed 10-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08832

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural — Sparks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mann Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME John J. Matthews

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Lena (nee Brewer)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1885

8. AGE: Years	Months	Days	If less than one day
62	9	2	..... hrs. ..... min.

9. Birthplace: Carleton, Balto Co., Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. D. M. Poole

Address: Sparks, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 28, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: A. A. Co., Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 10-25 (Date rec'd by registrar) 19 47 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 19 47, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from first attendance 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death	DURATION
Coronary occlusion	10 min.
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth B. Sterrill, M.D.

M. D. or other

Address: Cockeysville, Md. Date signed 10/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d

08833 42

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1825 Woodside Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1825 Woodside Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mack Atlis Mazzatenta

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Josephine Mazzatenta

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): February 12, 1891

8. AGE: Years	Months	Days	If less than one day
56	8	4	hrs. min.

9. Birthplace: Callecavino, Italy (Town, county, and state)

10. Usual occupation: Crane Operator

11. Industry or business: Arundel Corporation

FATHER

12. Name: Vincent Mazzatenta

13. Birthplace: Callecavino, Italy

MOTHER

14. Maiden name: Lucrezia Dipampsa

15. Birthplace: Callecavino, Italy

16. Informant: Mrs. Josephine Mazzatenta

Address: 1825 Woodside Avenue, Halethorpe

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10/18/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street

19. Oct 17 1947 (Date rec'd by registrar) C. W. Heinecke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1947 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1947 to Oct. 16 1947 and that I last saw him alive on Oct. 16, 1947

Immediate cause of death	DURATION
lung.	6 Mon
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Daniel A. Almadane M. D. or other

Address: 1945 W. Baltimore St. Date signed: Oct. 16, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08834

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Balto.

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 901 J. St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: S. C. County:

City or town: Florence.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 412 W. Darlington St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Shelley McKinley.

3.(b) Social Security Number: 250-14-6312.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Bertha.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 12/1898

8. AGE: Years	Months	Days	If less than one day
49	1	21	hrs. min.

9. Birthplace: Orange burg S. C.

(Town, county and state)

10. Usual occupation: Steel Worker

11. Industry or business: Sparrow Point Md

FATHER 12. Name: Robert McKinley

13. Birthplace: South Carolina

MOTHER 14. Maiden name: Belle McKinley

15. Birthplace: South Carolina

16. Informant: Bertha McKinley

Address: 412 W. Darlington St. Florence

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8. 1947 (month) (day) (year)

Cemetery or crematory: Old Baptist Cem.

Location: Florence S. C.

18. Funeral director: Elroy O. Wilson

Address: 1010 Bethley ave

19. 10-6-47 19.. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 19 47 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 19 47 to — 19..

and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Coronary disease	Sudden
Due to: Acute Atherosis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Learmonth M. D.

Deputy medical Examiner

Address: Florence S. C. Date signed: 10-3-47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08835

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4619 Ridgeway

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Leona F. McNally

3.(b) Social Security Number: 212-10-9553

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William F. McNally

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): May 22, 1902

8. AGE:

Years	Months	Days	If less than one day
45	5		...hrs. ...min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Stenographer

11. Industry or business: Black & Decker Co.

FATHER

12. Name: Gustavus Rudiger

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden name: Emma M. Wiseman

15. Birthplace: Baltimore, Md.

16. Informant: William F. McNally

Address: 4619 Ridgeway Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/47 (month) (day) (year)

Cemetery or crematory: Western Cem.

Location: Edmondson Ave.

18. Funeral director: M. W. E. Dippel's Sons

Address: 7110 Belair Road

19. Oct 24 1947 (Date rec'd by registrar) K. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1947, at 11 35 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 47 1947, to 10/22/47 1947

and that I last saw h... alive on 10 22 47 1947

Immediate cause of death: Ca of the Right Lung — DURATION: 6 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: F. Fred Ruppert M. D. or other

Address: 20 W. Lafayette Ave. Date signed: 10-24-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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Patterson Th. Ue.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08836

51C

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
216 Paradise Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 216 Paradise Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MATTHEW BARTON MERRICK

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Nan Pastorfield Merrick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1864

8. AGE: Years	Months	Days	If less than one day
83	5	4	hrs. min.

9. Birthplace: Talbot Co. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Samuel Beale Merrick
13. Birthplace: Talbot Co.

MOTHER
14. Maiden name: Mary Jane Barnes
15. Birthplace: Dorchester Co., Md.

16. Informant: Mrs. Arthur C. Bushey
Address: 216 Paradise Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10.11/47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 10/11 (Date rec'd by registrar) 19 47 D.W. Hedges Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9, 19 47 at 2:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 19 47 to October 9 19 47 and that I last saw him alive on October 9 19 47

Immediate cause of death	DURATION
Myocardial Decompensation	1 day
Due to: Carcinoma	6 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 10-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

08837

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk-22 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: 2925 Cornwall Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk-22 (If outside city or town limits, write RURAL and give nearest town)
Street No. 2925 Cornwall Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Adam Scott Mitchell

3.(b) Social Security Number: 194-01-3724

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes Rita Mitchell
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 24 December 1904

8. AGE:

Years	Months	Days	If less than one day
42	10		hrs. min.

9. Birthplace: Imperial-Allegheny-Pennsylvania (Town, county, and state)
10. Usual occupation: Clerk - Federal Gov't
11. Industry or business: Federal Gov't

FATHER
12. Name: William Mitchell
13. Birthplace: Scotland

MOTHER
14. Maiden name: Agnes Manclark
15. Birthplace: Scotland

16. Informant: Mrs. Agnes Mitchell
Address: 2925 Cornwall Rd.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 20, 1947 (month) (day) (year)
Cemetery or crematory: Grand View
Location: East McKeesport, Pa.

18. Funeral director: Roland L. Fisher
Address: 2112 Dundalk Ave

19. 10/19/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 October 1947 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 June 1947 to 18 October 1947 and that I last saw him alive on 18 October 1947

Immediate cause of death	DURATION
Coronary occlusion	4 months
Due to: Coronary arteriosclerosis	
Due to:	
Other conditions: Mild Diabetes Mellitus (Include pregnancy within 3 months of death)	3 years

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bernard W. Sollod M.D. M. D. or other
Address: 8 Lilac Ky Parkway Date signed: 18 Oct. 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137

08838

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford Co.

City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Cornelius Moore

3.(b) Social Security Number: 215-05-0799

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth Moore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 29 - 1914

8. AGE: Years	Months	Days	If less than one day
33	5	18	..... hrs. ..... min.

9. Birthplace: Cockeysville Md
(Town, county, and state)

10. Usual occupation: Service Station operator

11. Industry or business

FATHER
12. Name: Joseph C Moore
13. Birthplace: Cockeysville Md

MOTHER
14. Maiden name: Elizabeth Fitzpatrick
15. Birthplace: Harford Co Md

16. Informant: Personal History - Hospital Records

Address: Eudowood Sanatorium, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 20 47 (month) (day) (year)

Cemetery or crematory: St Joseph's

Location: Texas Md.

18. Funeral director: Chas F Goss.

Address: Bradshaw, Md.

19. Oct 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1947 at 6:10 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Oct 17 1947

and that I last saw h alive on Oct 16 1947

Immediate cause of death: Pneumonia, Tbc — DURATION: 7 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W A Bridges M. D. or other

Address: Towson 4, Maryland Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

B# 08839

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years, 11 months, 9 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 14 years, 11 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1465 Reynolds Street

(If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME

Kate Morasky

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph Morasky

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15, 1857

8. AGE: Years	Months	Days	If less than one day
89	10	15	hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: ?

13. Birthplace: Poland

MOTHER

14. Maiden name: ?

15. Birthplace: Poland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) 11/1/47

Cemetery or crematory: Holy Rosary Cem.

Location: Baltimore Co. Md.

18. Funeral director: Charles F. Hill

Address: 1501 E. Fort Ave

19. Oct 31 1947 (Date rec'd by registrar) A. W. Hyland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1947 at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 1932 to October 30 1947 and that I last saw her alive on October 30 1947

Immediate cause of death	DURATION
Gangrene of the right small toe (arteriosclerotic)	12 days
Due to: Generalized arteriosclerotic cardiovascular disease	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operation: \

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 10-30-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Unveruit 4280

Vet: 9320 P.O. - 303 ext 94a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08840

BC Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Sparrows Point -
City or town: Balto. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: about 20 minutes
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1216 Steelton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Graham H. Myers
3.(b) Social Security Number: S.S. 216-160-878

4. Sex: M
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Lydia A. Myers
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb. 2 - 1895

8. AGE: Years 52. Months 8. Days 15 — If less than one day ... hrs. ... min.

9. Birthplace: Murat Va.
(Town, county, and state)
10. Usual occupation: Night Manager Sparrow Point
11. Industry or business: Ship Yard Resturant
FATHER
12. Name: Unknown
13. Birthplace: "
MOTHER
14. Maiden name: "
15. Birthplace: "
16. Informant: Mrs. Lydia A. Myers.
Address: 1216 Steelton Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21-1947 (month) (day) (year)
Cemetery or crematory: Baltimore National Cem.
Location: Baltimore Md.
18. Funeral director: Mamie Cook-Syfer.
Address: 1600 W North Ave
19. Oct. 20, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17th 1947, at 10:35 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death: Coronary Occlusion — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?
23. SIGNATURE: M B Davis MD
Dep. Med. Examiner Balto Co.
Address: Dundalk 22 Md. Date signed: 10/17/47

VS A15 9-45-15M

I

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

108

08841

CERTIFICATE OF DEATH

Reg. Diat. No. 4430

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 8 months, 26 days

Hospital, Institution, or street address where death occurred:
Spring GroveState Hospital

How long in hospital or institution? 4 years, 8 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Turner's Station
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 15 Center Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Narutowicz
Stefen Narutowicz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Anna Visneiwski

6.(c) If alive, give age: ...years

7. Birth date of deceased (mo., day, yr.): 8/19/72

8. AGE: Years 75 | Months 2 | Days 5 | If less than one day: ...hrs. ...min.

9. Birthplace: Poland?
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Private

FATHER
12. Name: ?
13. Birthplace: Poland?

MOTHER
14. Maiden name: ?
15. Birthplace: Poland?

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1947 (month) (day) (year)

Cemetery or crematory: S.S. Stanislaus
Location: Dundalk Ave.

18. Funeral director: Roland L. Fisher
Address: 2112 Dundalk Ave.

19. 10/25/47 (Date rec'd by registrar) J. McKeever Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 19 47, at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 29 19 43, to October 24 19 47 and that I last saw him alive on October 24 19 47

Immediate cause of death	DURATION
Lobar pneumonia, right base	3 days
Due to: Generalized arteriosclerosis	indefinite
Due to: Hypertensive cardiovascular-renal disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Nature of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 10-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08842

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47C

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: ~~Parkville~~ Baltimore
City or town: ~~Baltimore~~ Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 9136 Ridge Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Parkville~~ / Baltimore
City or town: ~~Baltimore~~ Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9136 Ridge Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Andrew Neubeck

3.(b) Social Security Number: 218-05-5096

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elizabeth S.
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): November 12, 1879

8. AGE:	Years	Months	Days	If less than one day
	67	11	14	... hrs. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Joseph Neubeck
13. Birthplace: Germany

MOTHER
14. Maiden name: Frances Solmen
15. Birthplace: Gemrany

16. Informant: Mrs. Elizabeth S. Neubeck
Address: 9136 Ridge Avenue, 14

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-29-47 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Baltimore, Md.

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road, 14

19. 10-27 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Sept 1947 to Oct 26 1947
and that I last saw him alive on 8 October 1947

Immediate cause of death: Carcinoma, broncho-genic, left, lower lobe. DURATION: 4 yrs (?)

Due to
Due to
Other conditions: none.
(Include pregnancy within 3 months of death)

Major findings of operations: None except aspiration of rather typical whorls on bronchoscopy. Date of op. (approx) 6 Oct. 47 at Mercy Hosp. Balto. Md.
Autopsy results: not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edward L. J. Moz, M.D. (M. D. or other)
Address: 7329 Harford Rd. Balto. 14 Md. Date signed: 26 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08843

132

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 0 mos., 10 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 0 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1511 John Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. MARY NOVAK

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Eugene Novak

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): September 10, 1916

8. AGE: Years	Months	Days	If less than one day
31	1	6	hrs. min.

9. Birthplace: Pittsburgh, Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Valentine Gorski

13. Birthplace: Poland

MOTHER — 14. Maiden name: Catherine Trybus

15. Birthplace: Poland

16. Informant: Mrs. Mary Novak

Address: 1511 John St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/18/47 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: 4300 Old Frederick Rd., Balto., Md.

18. Funeral director: William Cook, Inc.

Address: 1217 St. Paul St., Balto., Md.

19. Oct. 16, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1947 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1947 to October 16, 1947 and that I last saw her alive on October 16, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed: 10/16/47

Rec'd. 10-21-47 Dr. E. Nichols - mw

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

08844

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred: Baltimore & Ware Aves

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore & Ware Avenues

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: Reverend James G. O'Neill

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): November 5, 1887

8. AGE: Years	Months	Days	If less than one day
59	11	10	...m...hrs. ...m...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Roman Catholic Priest

11. Industry or business: ---

FATHER — 12. Name: Matthew O'Neill

13. Birthplace: Not obtainable

MOTHER — 14. Maiden name: Margaret G. Galligan

15. Birthplace: Not obtainable

16. Informant: Church Records

Address: 408 N. Charles St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/17/47 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Maryland

18. Funeral director: H. W. Meakes and Son

Address: 805 N. Calvert Street

19. Oct 16 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 45 to October 19 47 and that I last saw h.e.r. alive on October 10 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Myocardial Degeneration	5 yrs.
Due to: Diabetes Mellitus	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D. M. D. or other

Address: 7301 York Rd Towson Date signed: 10/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 08845

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 602 Plymouth Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John J. Oster

3. (b) Social Security Number: 220-14-9249

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine Oster)
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1, 1872

8. AGE:

Years	Months	Days	If less than one day
75	6	24	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Groom
11. Industry or business: Victory Racing Plate Co
FATHER 12. Name: Jacob Oster
13. Birthplace: Germany
MOTHER 14. Maiden name: — Conrad
15. Birthplace: Germany
16. Informant: John J. Oster
Address: 602 Plymouth Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28-1947 (month) (day) (year)
Cemetery or crematory: London Park
Location: 3801 Fredrick Road
18. Funeral director: Mrs. Mrs. John H. Gentel & Son
Address: 5311 Edmondson Ave
19. Oct 27 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1947 at 1 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1947 to Oct 25 1947 and that I last saw h.. alive on Oct 24 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to Cachexia	
Other conditions Hypertension Cardio-Renal Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John J. Oster M. D. or other
Address: 1433 E. Baltimore St. Date signed: 10/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08846

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 yrs

Hospital, Institution, or street address where death occurred:

Dolfield Road Owings Mills

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dolfield Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME

Sarah Marcella Baker Parker

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Alexander F Parker

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 21 1860

8. AGE:

Years	Months	Days	If less than one day
87	8	17	..... hrs. ..... min.

9. Birthplace: Carroll County Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER

12. Name: Jurant W Baker

13. Birthplace: Carroll Co Md

MOTHER

14. Maiden name: - - Davis

15. Birthplace: Unknown

16. Informant: A Franklin Parker

Address: Owings Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof, Oct 10 1947 (month) (day) (year)

Cemetery or crematory: Old Oakland Cemetery

Location: Baltimore Co (Sykesville)

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. 10/8/1947 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8, 1947 at 1.15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to Oct 8, 1947 and that I last saw h alive on Oct. 7 1947

Immediate cause of death	DURATION
Cardio Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed 10/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

08847

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Balto. Co.
City or town Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County SPARROWS PT.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maraw Pennington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1872

8. AGE: Years	Months	Days	If less than one day
54	11	27	hrs. min.

9. Birthplace KENT Co MD
(Town, county, and state)
10. Usual occupation NURSE R.N
11. Industry or business

FATHER
12. Name EDMUND BURKE PENNINGTON
13. Birthplace DELEWARE

MOTHER
14. Maiden name MARY ANN TUCKER
15. Birthplace Balto. MD

18. Informant Elizabeth Pennington
Address KENNEDYVILLE MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10/27/47 (month) (day) (year)
Cemetery or crematory SHREWSBURY PARISH CEM.
Location KENNEDYVILLE MD.
18. Funeral director Charles A Cramer Inc
Address 118 W. Mt. Royal Ave

19. Oct 25 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1947 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 27 1947 and that I last saw h alive on Oct 23 1947

Immediate cause of death	DURATION
Cancer of Breast	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 520 DST Sparrows Pt. Md. Date signed 10-27-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08848

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2956 Sollers Point Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: EDWIN A. PETERSON

3.(b) Social Security Number: Unknown

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband/wife: Blanche Peterson

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 8-19-1891

8. AGE: Years: 56 Months: 1 Days: 26 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Frank Peterson
13. Birthplace: Sweden

MOTHER
14. Maiden name: Constance Jenson
15. Birthplace: Osler, Norway

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 18 47 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Frederick Road

18. Funeral director: Howard N. Blight Jr.
Address: 6009 Harford Road.

19. Oct 17 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 19 47 at 2:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 19 47 to October 15, 19 47 and that I last saw him alive on October 15, 19 47

	DURATION
Immediate cause of death: Infarction of right and left ventricles	10 Min.
Due to: Coronary Thrombosis	10 Min.
Due to: Arteriosclerosis of coronary arteries	Unknown
Other conditions: Chr. nephritis and Hypertension	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Padget.
PAUL PADGET, M.D. ACT. CLIN. DIR. M.D. or other
Address: VAH, FT. HOWARD, MD. Date signed: 10-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

37c

BC 08849

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Vet. Adm. Hospital, Fort Howard, Maryland
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 East York Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II ✓

3.(a) FULL NAME: PFAIFER, John B., Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Olive
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): 5-24-1911

8. AGE: Years	Months	Days	If less than one day
36	4	17	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business:

FATHER
12. Name: John Pfaifer
13. Birthplace: Poland

MOTHER
14. Maiden name: Lillian (maiden name unknown)
15. Birthplace: Poland

16. Informant: Clinical Records Vet.Adm.Hospital
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/47 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road

18. Funeral director: M. F. SADOWSKI AND SONS
Address: BALTIMORE, MARYLAND

19. Oct 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11th 1947, at 11:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10th 1947, to October 11th 1947 and that I last saw him alive on October 11th 1947

Immediate cause of death	DURATION
ROCKY MOUNTAIN SPOTTED FEVER, EASTERN VARIETY	2 weeks
Due to	
Due to	
Other conditions: ECZEMATOID DERMATITIS	9 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: Norman Oliver NORMAN OLIVER, M.D.
M. D. or other
Address: VAH, Fort Howard, Md. Date signed 10-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

08850 44

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto.

City or town Catonsville 21 Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred Rt 376, Tampa Rd. Hyde Park.

How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Couely

City or town Do

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME Joseph Gibbons Pfarr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Estelle Jane.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30/1884.

8. AGE:

Years	Months	Days	If less than one day
62	11	23	hrs. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual occupation Huckster

11. Industry or business Dairy Farmer.

FATHER

12. Name Louis P. Pfarr.

13. Birthplace Balto. Md.

MOTHER

14. Maiden name Sarah J. Birmingham

15. Birthplace Balto. Md.

16. Informant Louis P. Pfarr. Bro.

Address 2426 E. Hoffman St. Balto

17. Burial Date thereof Oct. 12. 47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Belair Rd

18. Funeral director John E. Miller.

Address 4435 E. Oliver St. Balto Md.

19. 10/8 1947 A. W. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7/x 7, to — 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

25. SIGNATURE J. McCormick M.D. Deputy Medical Examiner. M.D. or other

Address Rockville Md. Date signed 10/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

469 08851 30

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Balto.

City or town: 327 Westshire Rd. Balto. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Catonsville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 327 Westshire Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LAWRENCE W. PIQUETT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 10, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	1	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Milkman

FATHER
12. Name: John Phillip Piquett
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Louisa Frances ?
15. Birthplace: Balto. Md.

16. Informant: Mrs. Mary B. Wennagel
Address: 527 Westshire Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/14/47 (month) (day) (year)

Cemetery or Crematory: Lorraine Cem.

Location: Balto. Md.

18. Funeral director: WM. J. TICKNER & SONS INC.

Address: North & Pa. Aves. Balto. 17, Md.

19. Oct 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11, 1947 9:40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..., 19..., to ..., 19...

and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: Cardio Vascular Disease	
Other conditions: Cancer Pancreas	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. McKieffer Asst. Med. Exam. Balto. M. D. or other

Address: 1010 Leadenhall Date signed: Oct 11 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08852

200a

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 6 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or Institution? 2 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1006 Fawn Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Pasquale Platerote

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Clara Martucci

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): January 5, 1891

8. AGE: Years	Months	Days	If less than one day
56	9	1	...hrs. ...min.

9. Birthplace: Naples, Italy (Town, county, and state)

10. Usual occupation: City laborer

11. Industry or business: Baltimore City

MOTHER FATHER

12. Name: Joseph Platerote

13. Birthplace: Italy

MOTHER

14. Maiden name: Josephine Spagna

15. Birthplace: Italy

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/9/1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: 4400 Block Belair Road

18. Funeral director: Wendell J. Pippel

Address: 315 S. Highland Ave.

19. 10/8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1947, at 7:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1947 to October 6 1947 and that I last saw him alive on October 6 1947

Immediate cause of death	DURATION
Acute myocardial failure	1 day
Fever, undetermined origin	3 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 10-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 68853 57

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Baltimore

County.....

City or town.....Rural - Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....60 years

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or Institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Baltimore

City or town.....Cockeysville, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.....Dalton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Clarence Powell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Widowed

6.(b) Name of husband or wife.....Mary Jane (nee Powell)

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) — 7

8. AGE: Years	Months	Days	If less than one day
75	?	7	.....hrs. .....min.

9. Birthplace.....Balto. Co., Md.

(Town, county, and state)

10. Usual occupation.....Laborer

11. Industry or business

FATHER 12. Name.....Unknown

13. Birthplace

MOTHER 14. Maiden name.....Unknown

15. Birthplace

16. Informant.....Mr. Thos. Beard

Address.....Monkton, Md

17.....Burial.....Date thereof.....Oct. 27 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Stephenson

Location.....Sparks, Md.

18. Funeral director.....Landon M. Brooks

Address.....Sparks

19. 10-25- 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....24 October 1947 at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 June 1947 to 17 Oct. 1947

and that I last saw h.. alive on 17 Oct 1947

	DURATION
Immediate cause of death.....Cerebral Hemorrhage	1 day
Due to.....Arteriosclerosis	years
Due to.....	
Other conditions.....Arterio sclerotic heart disease	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE.....Walter T. Kees M. D.

M. D. or other

Address.....Cockeysville, Md. Date signed.....24 Oct. 1947

MARYLAND STATE DEPARTMENT OF HEALTH

~~BALTIMORE CITY HEALTH DEPARTMENT~~

CERTIFICATE OF DEATH

94a

Registered No. 08854 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

(a) Baltimore ~~City~~, Maryland

(b) Street address 7710 Park Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Parkville

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 7710 Park Drive
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Protzman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-1900

8. AGE: Years	Months	Days	If less than one day
47	4	17	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Gas & Electric Co.

11. Industry or business

FATHER 12. Name Conrad Peter Protzman

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Reutzel

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Margaret Protzman

(b) Address 7710 Park Drive, 14

17 (a) Burial (b) Date thereof 10-28-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial

Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (a) 10/27/47 (b) H. W. Kadrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1947, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1947, to Oct. 25 1947, and that I last saw h/ alive on Oct. 25 1947

Immediate cause of death Coronary Occlusion — Duration Sudden (1 hour)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Robert E. Williams M. D.

Address 2515 Taylor Ave. Date signed 10-28-47

Balto. 14, Md.

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

08855

38

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:
County: ~~Baltimore~~ Lawson
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 615 Hastings Ave.
How long in hospital or Institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Lawson
(If outside city or town limits write RURAL and give nearest town)
Street No. 615 Hastings Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bertha Ann Respess

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Married

6.(b) Name of husband or wife: Richard H. Respess
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1892

8. AGE: Years	Months	Days	If less than one day
55	7	24	..... hrs. ..... min.

9. Birthplace: Berlo, Md.
(Town, county, and state)
10. Usual occupation: H. W.
11. Industry or business

FATHER
12. Name: Franz Winter
13. Birthplace: Germany

MOTHER
14. Maiden name: Kunigunda
15. Birthplace: Germany

16. Informant: Richard H. Respess
Address: 615 Hastings Rd

17. Burial — Date thereof: Oct 23 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3901 Frederick Ave
18. Funeral director: Harry H. Kuhlke
Address: 4101 Edmondson Ave.
19. Oct 21 1947 H. W. Fabian
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20, 1947. 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to Oct 1947
and that I last saw h.. alive on Oct. 15 1947

Immediate cause of death	DURATION
Metastases — Generalized — Ca. Breast Rt.	2½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Rt. Breast Removed March 1945 Date of op. 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE: W. Richard Ferguson M. D. or other
Address: 1107 St. Paul Balto Date signed Oct 21 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G55672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a G55672 Registered No. 321

08856

1. PLACE OF DEATH: Baltimore C
(a) Baltimore City, Maryland
(b) Street address Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Richardson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Ethel
6 (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) March 27, 1890
8. AGE: Years 57 Months Days If less than one day hr. min.
9. Birthplace Wheeling W. Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Mrs. Ethel Richardson
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.
18 (a) Funeral director Mrs. Lucy H. Holland
(b) Address 1631 Druid Hill Av.
19 (a) 10/6/47 (Date rec'd by registrar) (b) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1947, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945, to 10-2 1947, and that I last saw h is alive on 10-2-4 1947.

Immediate cause of death Aortic Insufficiency — Duration ?
Renal disease — ?
Due to Aortic Dilation — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ben Horn M. D.
Address 1212 N Caroline Date signed 10/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS 150

~~Huntington Williams~~

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08857

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Roaches Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles H.Roach

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marion L.Roach

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 6,1865

8. AGE: Years	Months	Days	If less than one day
82	4	19	..... hrs. ..... min.

9. Birthplace: Hagerstown Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Charles Edward Roach

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Alice V.Rowland

15. Birthplace: Clear Spring Md.

16. Informant: Marion L.Roach

Address: Reisterstown,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct.27,1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Balto.Co.

18. Funeral director: J.F.Eline & Sons

Address: Reisterstown,Md.

19. Oct-27-1947 (Date rec'd by registrar) Mary B.Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 1947 19..... at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-26-'37 19..... to 10-24-'47 19.....

and that I last saw him alive on not seen alive 19.....

Immediate cause of death	DURATION
Arteriosclerotic C.-V. Disease	7 yrs.
Secondary Anemia	4 yrs.
Due to	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: I. D. Kaplan, M.D. M. D. or other

Address: Reisterstown, Maryland Date signed 10-25-'47

PLEASE WRITE PLAINLY, WITH UNFADING INK. - Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46f

08858

CERTIFICATE OF DEATH

Reg. Diat. No. 112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Balto Co.

City or town: Baltimore Arbutus (If outside city or town limits, write RURAL and give nearest town)

Street No. 1239 Maiden Choice Road (If rurel, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: Rev. PAUL J. ROETLING

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-14-95

8. AGE: Years	Months	Days	If less than one day
52	7	3	..... hrs. ..... min.

9. Birthplace: Buffalo, New York (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business

FATHER — 12. Name: John Roetling

13. Birthplace: Buffalo, N.Y.

MOTHER — 14. Maiden name: Pauline Stuermer

15. Birthplace: New York

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?). Date thereof: Oct. 21, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Md.

18. Funeral director: Frederick A. Wolf

Address: 1700 W. Lombard St.

19. Oct 21 1947 (Date rec'd by registrar) F. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1947 at 2:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1947 to October 17, 1947 and that I last saw him alive on October 17, 1947

	DURATION
Immediate cause of death: HEMORRHAGE, INTRAPERITONEAL	Sudden
Due to: Carcinoma of Liver, primary	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P. J. Oliver, M D (M. D. or other)

Address: VAH. Ft. Howard, Md. Date signed: 10-17-47

08859

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: BALTIMORE

City or town: BUTLER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: BALTIMORE

City or town: BUTLER

(If outside city or town limits, write RURAL and give nearest town)

Street No.: STRING TOWN ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: May Rorke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: SAMUEL E.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JULY 4, 1878

8. AGE: Years	Months	Days	If less than one day
69	3	17	..... hrs. ..... min.

9. Birthplace: BOOTON, N. J. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: OWN HOME

FATHER 12. Name: LOUIS FOUNTAINE

13. Birthplace: N. J.

MOTHER 14. Maiden name: RACHAEL

15. Birthplace: N. J.

16. Informant: ALLEN RORKE

Address: STRING TOWN ROAD BUTLER MARYLAND

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT 25 1947 (month) (day) (year)

Cemetery or crematory: MORELAND MEM. PARK

Location: PARKVILLE, MARYLAND

18. Funeral director: WILLIAM COOK, INC.

Address: 1217 ST. PAUL ST.

19. Oct 22 1947 (Date rec'd by registrar) J. W. Yadrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 19 47 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 46, to Oct 19 47 and that I last saw her alive on Oct. 12 19 47

Immediate cause of death	DURATION
Arteriosclerotic heart disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth B. Stovall, M.D. M. D. or other

Address: Cockeysville Md. Date signed 10/21/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

08860

Reg. Dist. No. 35-

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emanuel Elmer Rosier.

3. (b) Social Security Number: 717-07 6879.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mary Bell Rosier. 6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.): April 10, 1883.

8. AGE: Years 64 | Months 5 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Parkton, Md. R.D. (Town, county, and state)

10. Usual occupation: Watchman.

11. Industry or business: Railroad.

FATHER
12. Name: Abijah Rosier
13. Birthplace: Parkton, Md.

MOTHER
14. Maiden name: Eliza Tracey.
15. Birthplace: Balto., Co., Md.

16. Informant: Mary B. Rosier
Address: Parkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1947 (month) (day) (year)
Cemetery or crematory: Pine Grove U. B.
Location: Parkton Md. R.D.
18. Funeral director: Jacob Hartenstein
Address: New Freedom, Pa.

19. Oct 10 1947 (Date rec'd by registrar) Charles L. Engelman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1947 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to Oct. 7 1947 and that I last saw h... alive on Oct. 7 1947.

	DURATION
Immediate cause of death: Uremia	3 days
Due to:	
Due to:	
Other conditions: Chronic nephritis & hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. M. Florence M. D. or other
Address: Parkton, Md. Date signed: 10/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 08861

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Pt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
Street No. B. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John W. Ruley
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Julia Ruley
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.): Mar. 21 - 1886

8. AGE: Years	Months	Days	If less than one day
61	6	20	........hrs. ....min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: Elevator Operator
11. Industry or business: Epstein's Dept. Store
FATHER 12. Name: George Ruley
13. Birthplace: Balto. Md.
MOTHER 14. Maiden name: Elizabeth Smith
15. Birthplace: Balto. Md.
16. Informant: Nettie Herrmann
Address: B. St. Sparrows Pt. Md.
17. Burial Date thereof Oct. 13 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: Eastern Ave.
18. Funeral director: John A. Miller
Address: 2334 Jefferson St.
19. Oct 10 1947 A. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947, at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to Oct 10 1947 and that I last saw him alive on Oct 9 1947

	DURATION
Immediate cause of death: Arteriosclerotic Heart Dis	?
Due to	
Due to	
Other conditions: Chronic bronchitis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible], M.D.
M. D. or other
Address 520 D St. Sp Pt 19 Date signed 10/10/47

(I)

VS A15 9.45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08862

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Baltimore
City or town: Fork
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? (all life)
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Fork
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: W. Howard Sauer

3.(b) Social Security Number: 218-14-7415

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 1-1881

8. AGE:

Years	Months	Days	If less than one day
65	11	✓	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Augustus Sauer
13. Birthplace: Md.

MOTHER
14. Maiden name: Maria C. Fisher
15. Birthplace: Md.

16. Informant: Mrs. F. D. Taylor
Address: Hill ave Box 128 Towson 4 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4-47 (month) (day) (year)
Cemetery or crematory: Fork M. E. Cem.
Location: Fork Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md.

19. Oct 3 1947 (Date rec'd by registrar) C. E. Arthur Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1947, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19.. to .. 19..
and that I last saw him alive on .. 19..

Immediate cause of death	DURATION
Heart disease, coronary thrombosis with occlusion (Sudden)	10/2/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Rollin G. Hudson M.D. D.M.E.
M. D. or other
Address: Towson Md Date signed 10/2/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 08863 38

1. PLACE OF DEATH:
County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Annapolis Junction
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6518 Danbury Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Grace Irma Schenkel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 7, 1881

8. AGE: Years 66 | Months 8 | Days 14 | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation None
11. Industry or business None

FATHER
12. Name Thomas Schenkel
13. Birthplace Maryland

MOTHER
14. Maiden name Susan Riston
15. Birthplace Maryland

16. Informant Mrs Thomas Schenkel
Address 6520 Danbury Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/47 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Frederick Ave

18. Funeral director John F Denny Inc, Est'd.
Address 714 Light St.

19. 10-23 1947 (Date rec'd by registrar) D W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21st 1947, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/14 1945, to 10/21 1947 and that I last saw h.e.r alive on 10/18 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arterio Sclerosis	
Cardiovascular Renal disease	10 yrs
Due to Hypothyroidism	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles F O'Donnell MD M. D. or other
Address 7301 York Rd Date signed 10/25/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Dr. O'Connell
York Rd. & Stevenson Lane

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Dist. No. 088630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 N. Rolling Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GEORGE PHILIP SCHULBE

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Katherine Elizabeth
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	16	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: Real Estate
11. Industry or business
FATHER 12. Name: George P. Schulbe
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Miller
15. Birthplace: Germany
16. Informant: Mrs. Carrie Kimple
Address: 402 Northway Apt.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Baltimore, Maryland
18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY
19. Oct 29 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27, 1947 at 6.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 23 1939, to Oct - 27 1947 and that I last saw him alive on Oct - 27 - 1947

	DURATION
Immediate cause of death: Chr. Myocarditis	1 mo.
Due to: Diabetes Mellitus Senility	15 yrs.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: no Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S. Lloyd Johnson M. D. or other
Address: Catonsville, Md. Date signed 10-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 08865

Reg. Dist. No. 9 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since May 6, 1946
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Maryland
How long in hospital or institution? Since May 6, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3919 Rikeycroft Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ada M. Sexton

3. (b) Social Security Number 245-12-5349

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	~~Separated~~ Widowed

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 27, 1909

8. AGE: Years 37 | Months 10 | Days 22 | If less than one day hrs. min.

9. Birthplace Shenandoah VA (Town, county, and state)
10. Usual occupation Machine Operator
11. Industry or business

FATHER
12. Name Luther Burke
13. Birthplace Virginia

MOTHER
14. Maiden name Mary Vir
15. Birthplace Virginia

16. Informant Personal history - Hospital Records
Address Eudowood Sanatorium, Towson 4, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof 10/22/47 (month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Taylor Ave
18. Funeral director Howard N. Blight Jr.
Address 4914 Belair Road
19. Oct 21 1947 (Date rec'd by registrar) H. D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1947 at 12:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1946 to October 19 1947 and that I last saw h alive on October 19 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Since July 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. Bridges M. D. or other
Address Towson 4, Maryland Date signed 10-20-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

486 08866 44

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 73 Kinship Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine Shafe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William Shafe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 24 - 1877

8. AGE: Years	Months	Days	If less than one day
69	9	18	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Patrick Mc Intee

13. Birthplace Ireland

MOTHER 14. Maiden name Anna Sharkey

15. Birthplace Ireland

16. Informant Patrick Mc Intee

Address 73 Kinship Rd. Dundalk

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Oct. 12 - 47 (month) (day) (year)

Cemetery or crematory

Location Waynesburg, Pa.

18. Funeral director John J. Connelly

Address 418 Eastern Ave. Catonsville

19. Oct. 12 1947 John J. Connelly Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1947 at 4.00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Oct 12 1947 and that I last saw her alive on Oct 11 1947.

Immediate cause of death	DURATION
Carcinoma of uterus	10 mos.
Due to metastasis to mesenteric glands	8 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE David H. Andrews M.D.

Address 2 Kinship Rd Dundalk Md M. D. or other

Date signed 10/12/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 08867

1. PLACE OF DEATH:
(a) Baltimore ~~City,~~ Maryland
(b) Street address 409 Schwartz Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Schwartz Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Jane Short

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Howard County Md.
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Joseph Scott
13. Birthplace Howard County

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Housework

16 (a) Informant William T. Short
(b) Address 409 Schwartz Ave

17 (a) Buried (b) Date thereof Oct. 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. A. Elliott Dept.
(b) Address 1129 N. Caroline St.

19 (a) Oct 7 1947 (b) Huntington Williams Reg'str
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947, to Oct 6 1947 and that I last saw h— alive on Oct 6th 1947.

	Duration
Immediate cause of death Subarachnoid Hemorrhage	13 days
Due to Arterial Hypertension	5 yrs.
Due to Nan	
Other Conditions Nan	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: Non

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 610 York Rd Date signed Oct 6 47 M. D.

VS 150 [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

169 08868

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Joseph SIMMONS, Joseph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MM	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15 1916

8. AGE: Years	Months	Days	If less than one day
31	6	1	hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: Henry B. Simmons
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary E. Kenly
15. Birthplace: Md

16. Informant: Margaret Mc Kenna
Address: 3149 Elmora Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/17/47 (month) (day) (year)
Cemetery or crematory: Meadow Ridge
Location: Dorsey Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul st.
19. Oct 17 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 19 47 at 7 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Run Down by Train at Dorsey Jct 3rd Rail & body	
Due to: severed	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 10/16/47
Where did injury occur? Dundalk (City or town) Balto (County) Md (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Run over by Train Injured at work? No

23. SIGNATURE: M. Brown M.D.
Address: Dep. Med. Examiner, Balto. Co. or other Dundalk R.F.D. Md. Date signed: 10/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83 b

08869

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Balto.

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
4323 Belmar Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4323 Belmar Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CLARA MAY SMITH

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of hueband or wife: Harry G. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 28th, 1860

8. AGE: Years	Months	Days	If less than one day
87	0	8	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Indueiry or business

FATHER — 12. Name: Wm. Stevens

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Christine Roelkey

15. Birthplace: Maryland

16. Informant: Miss Nellie Smith

Address: 4323 Belmar Ave., Balto. 6, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10/9/47 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore, Md.

18. Funeral director: Loveless Funeral Home

Address: 7401 Belair Road

19. Oct 7- 19 47 (Date rec'd by registrar) Mrs. A. L. Reffenider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6th, 19 47, at 2:40A.M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from April 1st, 19 46, to Oct. 6th 19 47

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 weeks
Myocardial Insufficiency	3 weeks
Due to: Arterio-sclerosis	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, eulcide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edwin Benson
M. D. or other

Address: 1W. Overlea Ave. Date signed: 10/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466 18870

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: BALTIMORE COUNTY
City or town: TOWSON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: BALTO
City or town: TOWSON
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1001 W. JOPPA RD
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SISTER MARY JOSEPHINE Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN. 8, 1870

8. AGE:

Years	Months	Days	If less than one day
77	9	1	hrs. min.

9. Birthplace: PHILA, PA (Town, county, and state)
10. Usual occupation: NUN
11. Industry or business: CONVENT
FATHER 12. Name: THOMAS SMITH
13. Birthplace: IRELAND
MOTHER 14. Maiden name: MARY MEEHAN
15. Birthplace: IRELAND
16. Informant: RECORDS OF MISSION HELPERS CONVENT
Address: 1001 W. JOPPA RD, TOWSON
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 10/11/47 (month) (day) (year)
Cemetery or crematory: MISSION HELPERS CONVENT GROUNDS
Location: 1001 W. JOPPA RD. TOWSON
18. Funeral director: C. Vernon Lemmon
Address: 4611 PK. HGTS, BALTO. CITY
19. 10/11 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 OCT. 19 47, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Aug. 19 47, to 9 OCT. 19 47 and that I last saw her alive on 26 Oct. 19 47

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Diaphragmatic Hernia & Gastric Carcinoma inoperable Date of op. 18 Aug 47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. W Dearing M. D. or other
Address: 4 Bradleigh Av. Towson 4 Date signed: Oct 13 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

08871

CERTIFICATE OF DEATH

Reg. Dist. No. 57

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Michael G. Smedley

3.(b) Social Security Number: 212-26-5765

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Nellie (nee Sloyd)

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): May 22, 1893

8. AGE: Years	Months	Days	If less than one day
54	5	8	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Grinder

11. Industry or business: Black & Decker Mfg Co

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. M.G. Smedley

Address: Sparks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 2, 1947 (month) (day) (year)

Cemetery or crematory: Black Rock

Location: Berths, Maryland

18. Funeral director: Landon M. Booth

Address: Sparks, Md.

19. Oct. 31- 47 (Date rec'd by registrar) 19 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30 19 47, at 11 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19 46, to Oct. 30 19 47

and that I last saw him alive on Oct. 30 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. M. France M. D. or other

Address: Parkton, Md. Date signed: 10/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45 b

08872

ac

Reg. Dist. No. 44

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2328 W. Lexington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: CHARLES B. STEVENSON

3. (b) Social Security Number: 218-07-9651

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Pauline Stevenson

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): November 4, 1912

8. AGE: Years	Months	Days	If less than one day
34	11	21	..... hrs. ..... min.

9. Birthplace: Govanstown, Md.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: Arthur Stevenson
13. Birthplace: unknown

MOTHER
14. Maiden name: Nellie Pumphrey
15. Birthplace: Maryland

18. Informant: Clinical Records, Vets.Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: 5501 Frederick Rd. Balto. Md.

18. Funeral director: William J. Tickner & Sons

Address: North & Pennsylvania Aves. Balto. Md.

19. Oct 27 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 19 47 at 2:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 19 47 to October 25 19 47 and that I last saw him alive on October 25 19 47

Immediate cause of death	DURATION
Tuberculosis, pulmonary, advanced, bilateral	16 plus
Due to	
Due to	
Other conditions: Carcinoma of tongue	9 mos plus
Tuberculosis of ileum, slight	16 days plus

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George Lerner GEORGE LERNER, M.D. M. D. or other

Address: VETERANS ADMINISTRATION HOSP. FORT HOWARD, MD. Date signed 10-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08873

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH:

County Baltimore.-

City or town Rural near Parkton.-

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 years.-

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Rural near Parkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rayville.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John E. Stiffler.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife Gertrude R. Stiffler

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 29, 1870.

8. AGE:

Years	Months	Days	If less than one day
76	9	21	hrs. min.

9. Birthplace Parkton, Md. R.D.-
(Town, county, and state)

10. Usual occupation Carpenter.

11. Industry or business Carpentering.

FATHER 12. Name John Stiffler.

13. Birthplace Md.

MOTHER 14. Maiden name Sarah Baublitz.

15. Birthplace Md.

16. Informant Mark R. Stiffler

Address Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23 1947 (month) (day) (year)

Cemetery or crematory Pine Grove E.U.B.

Location Parkton, Md. R.D.

18. Funeral director Jacob Hartzler Stein

Address New Freedom, Pa.

19. Oct 22 1947 (Date rec'd by registrar) Charles L. Pearce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1947 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.. to 19..

and that I last saw alive on 19.. and that death occurred on 19..

Immediate cause of death	DURATION
Coronary Artery disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. M. Frank M. D. or Other

Address Parkton, Md. Date signed 10/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08874

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 6 mos., 17 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 1 yr., 6 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. George

City or town: Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Newell Major Swartz

3. (b) Social Security Number: 579-01-4796

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Harriet Swartz

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): May 17, 1913

8. AGE:

Years	Months	Days	If less than one day
34	4	27	....hrs. ....min.

9. Birthplace: Warm Springs, Va. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER

12. Name: Newell T. Swartz,

13. Birthplace: Natural Bridge, Va.

MOTHER

14. Maiden name: Elizabeth Givney

15. Birthplace: Mint Springs, Va.

16. Informant: Newell M. Swartz

Address: Brandywine, Pr. Geo. Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 16, 1947 (month) (day) (year)

Cemetery or crematory: Ivy Hill Cemetery

Location: Laurel, Md.

18. Funeral director: DeWitt Donaldson

Address: Laurel, Md.

19. 10/13/47 (Date rec'd by registrar) 19.... Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13, 1947 at 9:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1946 to Oct. 13, 1947 and that I last saw him alive on October 13, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	2 yrs.
Due to: Tuberculous Empyema	9 mos.
	1 yr.
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed 10/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

08875

CERTIFICATE OF DEATH

33

Reg. Dist. No.

1. PLACE OF DEATH: Balto.
County
City or town: R.F.D. near Mutt. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
Grace Mutt. Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Northington Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No. Park Heights Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elsie Janten Symington.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed.

6.(b) Name of husband ~~or wife~~ Donald [redacted] Symington

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24, 1884.

8. AGE: Years	Months	Days	If less than one day
63	3	26	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name J. Hillen Jenkins.
13. Birthplace Baltimore, Maryland.

MOTHER 14. Maiden name Rebecca Smith.
15. Birthplace Baltimore, Maryland.

16. Informant Arthur L. Foster, Jr.
Address Glyndon, Maryland.

17. Burial. Date thereof Oct. 22, '47.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Thomas.
Location Garrison, Maryland.

18. Funeral director Henry W. Jenkins & Sons.
Address Orchard & McCulloh St., Balto. Md.

19. Oct 21 1947 W. W. Fedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1947, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Oct 20 1947
and that I last saw her alive on Oct 20 1947

	DURATION
Immediate cause of death Carcinoma Breast.	1940
Due to	
Due to	
Other conditions Gen'l Metastases.	1946

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results W.D.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Palmer H. Williams M. D. or other
Address Pikesville 8, Md. Date signed Oct 20. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08876

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Mar-Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, institution, or street address where death occurred:
Annapolis Home
How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Md County Baltotity
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Tudor Arms Apt.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Washington Tall

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Eliza A Tall
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec-31-1863
8. AGE: Years 83 | Months 9 | Days 25 | If less than one day ..... hrs. ..... min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Retired - Tall Bros
11. Industry or business Printing
FATHER 12. Name Geo W. Tall
13. Birthplace Dorchester Co. Md.
MOTHER 14. Maiden name Amanda Jones
15. Birthplace Virginia
16. Informant Lusher Tall - (son)
Address 4429 Kirkford Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-28-47 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville Md
18. Funeral director STEWART & MOWEN COMPANY
Address (W. F. MOWEN SR.) 104 W. NORTH AVENUE
19. Oct 27 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1947, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 / 47 1947, to Oct 25 1947 and that I last saw h.... alive on Oct 24 1947

Immediate cause of death	DURATION
Cerebral Vascular Accident	6 wks
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Francis W Gluck M.D.
M. D. or other
Address 3406 St Paul St Date signed 10/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1312

Reg. Diat. No. 088728

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 3 mohths, 19 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 5 years, 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2523 West Pratt Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ENLISTMENT — 1890-1896 ✓

3. (a) FULL NAME

John W. Temple

3. (b) Social Security Number

NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Bertha Lyeth

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 5, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	8	hrs. min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Car builder; odd jobs

11. Industry or business: Miscellaneous

FATHER
12. Name: James Hilton
13. Birthplace: Ireland

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. BURIAL
(Burial, cremation, or removal. Which?)
Date thereof: OCTOBER 17, 1947
(month) (day) (year)

Cemetery or crematory: LONDON PARK

Location: FREDK. AVE., BALTIMORE, Md.

18. Funeral director: Walter Bowie Bradley

Address: 1922 W. NORTH AVE.

19. Oct 16 1947 A. W. Hyfield
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 19 47 at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 19 42 to October 13 19 47

aed that I last saw h im alive on October 13 19 47

Immediate cause of death	DURATION
Broncho pneumonia	8 days
Due to: Cerebral accident	2 weeks
Due to: Chronic hypertensive cardio-vascular-renal disease	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 10-14-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

(5)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

08878

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE PRINT PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Name is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

County: Balto.

City or town: Middle River (Dark Head)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 51 Darkhead
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Margaret Thompson

3.(b) Social Security Number: 214-10-5258

4. Sex: F.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Theodore E. Thompson

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Nov. 29 - 1910

8. AGE: Years: 36 (96) Months: Days: If less than one day: hrs. min.

9. Birthplace: Frederick, Md.
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Glenn L. Martin Co.

FATHER
12. Name: Curtis Cline
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Alice L. Biddinger
15. Birthplace: Frederick, Md.

16. Informant: Theodore E. Thompson
Address: 51 Darkhead,

17. Burial — Date thereof: Oct. 23-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick, Md.

18. Funeral director: John G. Connelly
Address: 418 Eastern Ave.

19. Oct. 21 1947 — John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20th 1947, at 10:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19.... and that I last saw h.... alive on .... 19....

Immediate cause of death: DROWNING — DURATION:

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental — Date of: 10/21/47.

Where did injury occur? Middle River, Balto. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): DARK HEAD CREEK

Means of injury: Boat upset — Injured at work? No.

23. SIGNATURE: M B Davis M.D.
Dep't Med. Examiner, Balto. Co., Md. — M. D. or other

Address: Dundalk-22- — Date signed: 10/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08879

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Balto.

City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
2910 Onyx Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2910 Onyx Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ELEANOR P. THRASHER (nee Simmons)

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Willian C. Thrasher, Sr.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 10, 1871

8. AGE: Years	Months	Days	If less than one day
76	9	17	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Richard L. W. Simmons
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary E. Higdon
15. Birthplace: Baltimore, Md.

16. Informant: Mr. Randolph H. Thrasher son
Address: 2910 Onyx Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/29/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. Oct 28 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27, 1947, at 7 30/A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1938 to October 27 1947 and that I last saw her alive on October 27, 1947

Immediate cause of death	DURATION
Uremia - due to	1 wk.
Arteriosclerosis & old cerebral accident	
Due to Senility. 11/29/47 G.S.	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ernest Levi, M.D. M. D. or other

Address: 601 N. Broadway Date signed: 10/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08880

CERTIFICATE OF DEATH

Reg. Diat. No. 9 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Maryland

How long in hospital or institution? 2 mo. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 N. Kossuth St
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Laura Valade

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Joseph L. Valade

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1887

8. AGE:

Years	Months	Days	If less than one day
60	3	9	hrs. min.

9. Birthplace: Canada
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joseph Brock
13. Birthplace: Canada

MOTHER
14. Maiden name: Celia Crandle
15. Birthplace: Canada

16. Informant: Personal History - Hospital Records

Address: Eudowood Sanatorium, Towson 4, Maryland

17. ~~Burial~~ Removal Date thereof: 10-7-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory:

Location: Bridgewater, Mass.

18. Funeral director: George A Farley

Address: Frederick + Hodgson Bros. Caterers

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1947 at 6.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1947 to Oct 5 1947 and that I last saw h[illegible] alive on Oct 4 1947

Immediate cause of death: Pulmonary TBC — DURATION: 5 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W G Bridges M. D. or other

Address: Towson 4, Md. Date signed:

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

* File as Vaughn

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 23742

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address Tourist Cabin-Wash. Blvd.
(c) ~~Hospital or institution.~~ City
nr. Hyattsville
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 08881
(a) State Ohio (b) County
(c) City or town Pataskalla
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. Pat. McQuire * (Charles Vaughn)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Charles Vaughn
13. Birthplace Unknown Ohio

MOTHER
14. Maiden Name Elma Fulton
15. Birthplace unOhio n

16 (a) Informant neubert vaughn
(b) Address Landover Md.

17 (a) transportation (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Oct. 15/47
(c) Cemetery or crematory Grove City Ohio
Location Grove City Ohio

18 (a) Funeral director F. Gasch's Sons
(b) Address Hyattsville, Maryland

19 (a) 10/14/47 (Date rec'd by registrar) (b) Amanda E. Downey Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1947 at 5 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive hemorrhage due to multiple wounds of head, face, neck, & shoulder

Due to

Other Conditions Small linear fracture of skull

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-12-47 at 5 p. M.
(b) Where did injury occur? Tourist Cabin-Wash. Blvd. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt force

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 10-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08882

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County: Baltimore

City or town: Govy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Govy

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1320 Hollins Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gilbert Travis Haldeman Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Alice Anne Haldeman (Deceased)

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): March 17 - 1882

8. AGE:

Years	Months	Days	If less than one day
65	7	9	... hrs. ... min.

9. Birthplace: New York City (Town, county, and state)

10. Usual occupation: Builder (Retired)

11. Industry or business

FATHER — 12. Name: Benjamin Haldeman

13. Birthplace: N.Y.C.

MOTHER — 14. Maiden name: Lowel Gilbert

15. Birthplace: N.Y.C.

16. Informant: Gilbert Haldeman Jr.

Address: 1320 Hollins Ave.

17. Rural (Burial, cremation, or removal. Which?) Date thereof Oct. 28-47 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Chase 2nd

18. Funeral director: John G. Connelly

Address: 417 Eastern Ave Govy

19. Oct 28 1947 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1947, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Oct. 1947 to 26 Oct 1947 and that I last saw him alive on dead on ARRIVAL 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Myocarditis	12 yrs.
Due to: Arteriosclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Maxwell T. Mennel M.D. M. D. or other

Address: 417 E Eastern Ave Date signed 10-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08883

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Balto

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1728 Russ Rd

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1728 Russ Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William H. Waltman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Date of birth (mo., day, yr.): June 2 1876

AGE: Years: 71 Months: 4 Days: 4 If less than one day: ... hrs. ... min.

9. Birthplace: Carroll Co Md (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Stationary Engineer

FATHER — 12. Name: Wm Waltman

13. Birthplace: Md

MOTHER — 14. Maiden name: unknown

15. Birthplace: Md

16. Informant: William H Waltman

Address: Russ Rd

17. Burial: Burial, cremation, or removal. Which? Date thereof: Oct 8. 47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem

Location: Woodlawn Balto

18. Funeral director: Geo L Schmidt

Address: 701 Federal ave

19. Oct 7 47 (Date rec'd by registrar) G. McKieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1947 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to	
Due to Cardiovascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: G. McKieffer Asst Med Exam Balto M. D. or other

Address: 1010 Leadenhall Date signed: Oct 7, 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians write the causes of death clearly and legibly.

08884

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

309

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hosp.Ft.Howard,Md.
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 919 Cedar Park Road
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-1 ✓

3. (a) FULL NAME: GEORGE E. WARD, SR.

3. (b) Social Security Number: 216-10-2524

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Husband or wife: Mary E. Ward
6.(c) If alive, give age: 53 years

7. Date of birth (mo., day, yr.): 3-17-91

8. Age:

Years	Months	Days	If less than one day
56	6	14	..... hrs. ..... min.

9. Birthplace: Coatesville, Indiana
(Town, county, and state)

10. Usual occupation: Motorman

11. Industry or business: Railroad

FATHER
12. Name: William Ward
13. Birthplace: Indiana

MOTHER
14. Maiden name: Mary Brown
15. Birthplace: Indiana

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1947 (month) (day) (year)
Cemetery or crematory: All Hallows Cemetery
Location: Davidsonville, Md.

18. Funeral director: B. L. Hopping and Son
Address: Annapolis, Md.

19. Oct. 3 1947 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 19 47 at 11:50P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 2 19 47 to October 1 19 47 and that I last saw him alive on October 1 19 47

Immediate cause of death	DURATION
Disease of Heart	3 mos.
Cause:Coronary arteriosclerosis	
~~xxx~~ Structural Lesion:Myocardial damage	
~~xxxx~~ Manif.:Myocardial insufficiency auricular fibrillation	
Other conditions: Syphilis,latent,late adequately treated	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

RL Robert M. Cullison
23. SIGNATURE: R.M.CULLISON, M.D. CLIN. DIR.
Veterans Administration Hosp.
Address: Fort Howard, Md. Date signed: 10-2-47

08885

46 e

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Baltimore County
City or town Rural Timonium Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Rural Timonium Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Salona Farms
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish Amer & World War 1

3. (a) FULL NAME Henry Mactier Warfield

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of ~~husband~~ or wife Rebecca C D Warfield
6.(c) If alive, give age 79 years
7. Birth date of deceased (mo., day, yr.) July 1 1867

8. AGE: Years 80 Months 3 Days 9 If less than one day ...hrs. ...min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Pres, Riggs Warfield Roloson Co
11. Industry or business Insurance

FATHER
12. Name Henry Mactier Warfield
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Anna Emory
15. Birthplace Manor Glen Baltimore Co

16. Informant Z R Lewis (Son in Law of Deceased)
Address Timonium Md

17. Burial (Burial, ~~cremation or removal~~, Which?) Date thereof Oct 13 1947 (month) (day) (year)
Cemetery or crematory Green Mount 10/12/47
Location Baltimore City
18. Funeral director Henry W. Jenkins & Sons Co
Address McCulloh & Orchard Sts.

19. 10/11 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 10 1947
and that I last saw him alive on Oct 9 1947

Immediate cause of death: Carcinoma - Sigmoid

Due to: General Break Down from Old age

Due to:

Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] Baeger M. D. or other
Address 1101 St Paul St Date signed Oct 10/47

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Diat. No. 088643

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, Institution, or street address where death occurred: Belair Road

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Fullerton (If outside city or town limits, write RURAL and give nearest town)

Street No. Belair Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William A. Watkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Hannah J Watkins

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): July 3rd 1862

8. AGE: Years 85 | Months 3 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Railroad Engineer

11. Industry or business

FATHER — 12. Name: Wm J. Watkins

FATHER — 13. Birthplace: Harford Co Md.

MOTHER — 14. Maiden name: Sufronia Streett

MOTHER — 15. Birthplace: Harford Co Md.

16. Informant: Glen A. Watkins

Address: 8420 Old Harford Rd Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21-1947 (month) (day) (year)

Cemetery or crematory: Highland Cem.

Location: Streett, Md.

18. Funeral director: Hubert P. Watkins.

Address: Delta, Pa.

19. Oct. 18 1947 (Date rec'd by registrar) Mrs. A. L. Reisinger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18th 1947, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 16th 1947, to Oct 18 1947.

and that I last saw him alive on Oct 17th 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to: Arterio Sclerosis	5 yrs
Due to: hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward A. Geesey M. D. or other

Address: 1 W. Orelus Ave. Date signed 10/18/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930

0888732

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Pikesville

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Neighborhood Home - Campfield Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Neighborhood Home

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Watzke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Andrew Watzke

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April - 22 - 1866

8. AGE:

Years	Months	Days	If less than one day
81	6	4	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER — 12. Name: Herman Pulkmann

13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Petarch

15. Birthplace: Germany

16. Informant: Theo. Peter Bamb - Friend

Address: Neighborhood Home Campfield Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 - 29 - 47 (month) (day) (year)

Cemetery or crematory: Druid Hill Cem.

Location: Druid Hill Ave

18. Funeral director: John O. Miller Inc

Address: 2435 E. Oliver St

19. Oct 29 1947 (Date rec'd by registrar) A. W. Beard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 29 - 1947 at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 7 - 1947 to Oct. 36 1947 and that I last saw h.e.r alive on Oct. 34 - 1947

Immediate cause of death	DURATION
1.) Bronchio - pneumonia	7 days.
Due to	
Due to	
Other conditions - Chronic Arteri - Sclerotic Heart Disease -	5 years.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other

Address: 4108 Liberty Hts. Date signed: 10/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94b 08888 43

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use complete name and address if information is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 100 Roope Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Overlea

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 Roope Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Mary Emma Wells

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Henry L. Wells

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 8 1863

8. AGE: Years: 84 Months: 7 Days: 24 If less than one day: hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER

12. Name: Jacob A Wells

13. Birthplace: Baltimore Md

MOTHER

14. Maiden name: Mary E Marsh

15. Birthplace: Baltimore Md

16. Informant: Irving Wells

Address: 6309 Bombay Rd

17. Burial, cremation, or removal: Burial Which?

Date thereof: 10/7/47 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md

18. Funeral director: Wilson Cook Inc

Address: 1317 E Paul St

19. 10/4/47 (Date rec'd by registrar) A W Fredrich J.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 47 19 to Aug 2 47 19

and that I last saw h.. alive on Aug 2 47 19

Immediate cause of death	DURATION
Senility	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 2430 Pine Ave Date signed: 10 3 47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

Registered No. 08889

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: (a) Baltimore ~~City~~, Maryland
(b) Street address 615 S. 46th. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. 46th. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILHELM WIITALA

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 219-03-3347

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Serafia Wiitala
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1880

8. AGE: Years 66 | Months 1 | Days 5?
If less than one day: hr. min.

9. Birthplace: Finland
(Town, county, and state)

10. Usual Occupation: Steel worker

11. Industry or business

FATHER
12. Name: John Wiitala
13. Birthplace: Finland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Finland

16 (a) Informant: Mr. Martin J. Wiitala
(b) Address: 615 S. 46th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Oct 25, 47 (Date rec'd by registrar) (b) D. W. Strickler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1947, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Oct 23 1947, and that I last saw him alive on Oct 20 1947.

	Duration
Immediate cause of death: Carcinoma of the lungs	3 mos.
Due to:	
Due to:	
Other Conditions: arteriosclerosis cancer, gangrene and amputation of left leg (Include pregnancy within 3 months of death)	5 yrs.
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: David K. Andrew M.D. M. D.
Address: Kingsley Rd Date signed 10/27/47
Klondike (22) md

V S 150

MARYLAND STATE DEPARTMENT OF HEALTH
State Office Building, 301 W. Preston St., Baltimore

CERTIFICATE OF DEATH

83w

Reg. Dist. No. 08890 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Railroad Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Nancy Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Widow

6.(b) Name of husband or wife: Henry Wilson deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 4, 1867

8. AGE:

Years	Months	Days	If less than one day
80	6	2	..... hrs. ..... min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

MOTHER FATHER
12. Name: Samuel Devine
13. Birthplace: Maryland
14. Maiden name: Mary Boley
15. Birthplace: Maryland

16. Informant: Bertha Reed
Address: 631 W. Saratoga St. Balt. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 8, 1947 (month) (day) (year)
Cemetery or crematory: Basil A.M.E.
Location: Cockeysville, Md.
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

10-8 47 Wilmer C. Ensor
19. ..... 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 October 19 47, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 October 19 47, to 5 October 19 47
and that I last saw h.. alive on 5 October 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to: Hypertension	?
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Walter T. Kerr M.D. M. D. or other
Address: Cockeysville, Md. Date signed: 10-5-47